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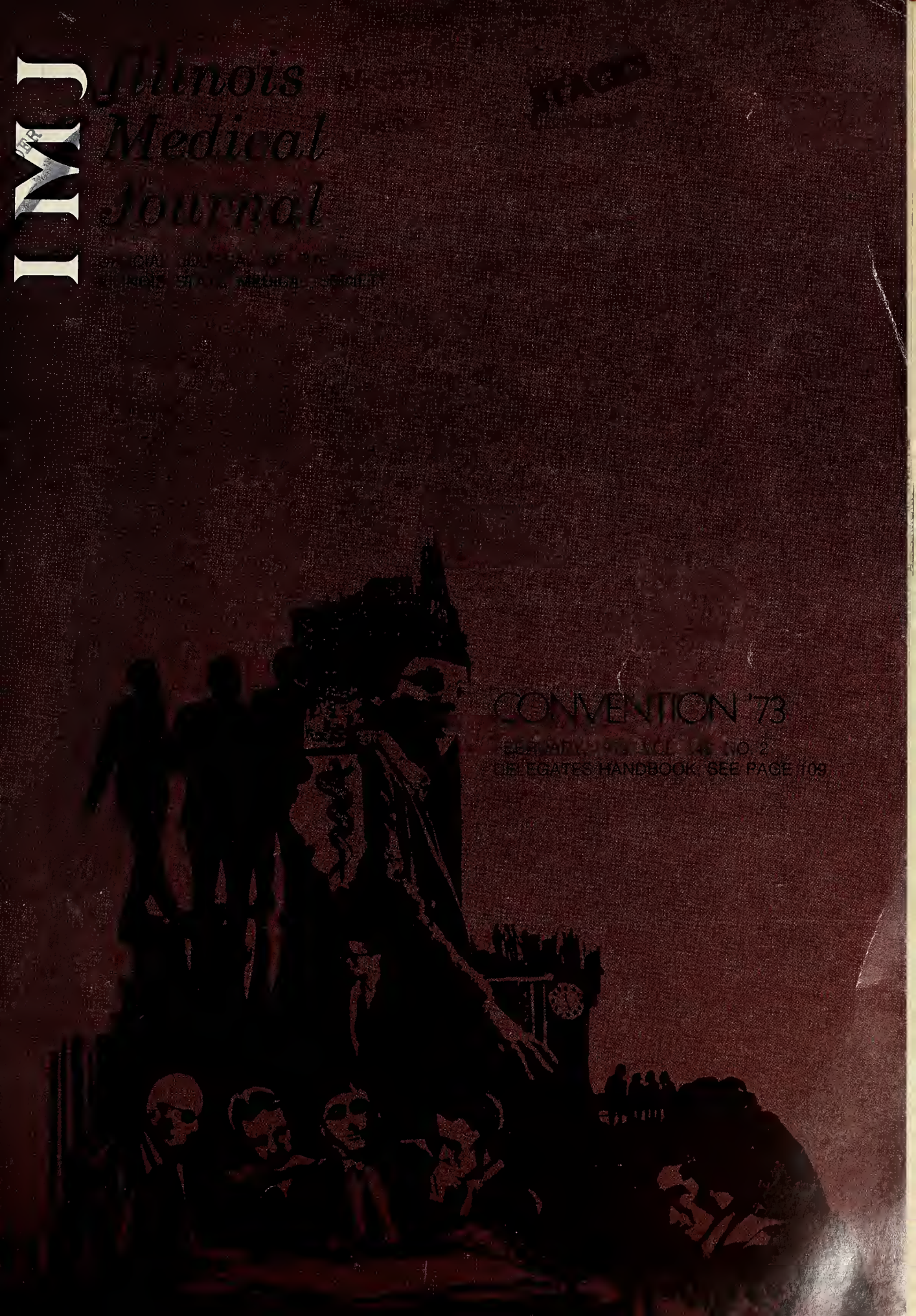
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IMJ

Illinois Medical Journal

OFFICIAL JOURNAL OF THE
ILLINOIS STATE MEDICAL SOCIETY



CONVENTION '73

SEE JANUARY 1973 VOL. 143, NO. 2

DELEGATES HANDBOOK SEE PAGE 109

Integument!

Our skin—the human integument—covers us, defines us, protects us. But skin is subject to cuts, burns, abrasions. And infections. Neosporin Ointment fights infection by providing broad antibacterial action against susceptible skin invaders. It contains antibiotics that are rarely used systemically, reducing the risk of sensitization.

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INDICATIONS: *Therapeutically*, used as an adjunct to appropriate systemic therapy for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection.

Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components.

PRECAUTION: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Complete literature available on request from Professional Services Dept. PML.

NEOSPORIN® Ointment

(POLYMYXIN B-BACITRACIN-NEOMYCIN)

Each gram contains: Aerosporin® brand Polymyxin B Sulfat 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg. neomycin base); special white petrolatun q.s. In tubes of 1 oz. and ½ oz. and 1/32 oz. (approx.) foil packets

Wellcome / **Burroughs Wellcome Co.**
Research Triangle Park
North Carolina 27709

71-829

BLUE SHIELD REPORT FOR Illinois Physicians

Local Insert

Alternatives For Non-Covered Inpatient Diagnostic Admissions

Because benefits for inpatient diagnostic admissions are excluded from nearly all Blue Cross-Blue Shield contracts, new programs have been announced, effective January 1, 1973, that will provide outpatient diagnostic benefits to many of our existing contracts.

There will be an automatic addition of diagnostic outpatient benefits in our Series A, A-80 and B programs, and all of the community-rated groups without these benefits will have them after the first of the year. Approximately 20 of the community-rated groups already have the benefits by means of a "rider".

Benefit Scope

The outpatient diagnostic benefits will include X-ray, laboratory and pathology services, electroencephalograms, electrocardiograms, basal metabolism tests and radioisotope tests when such services are intended for diagnosis of a definite condition, disease, injury or complaint billed by a hospital or physician.

Services do not include X-ray, laboratory or pathology services rendered in connection with routine, periodic, or annual physical examinations or check-ups, premarital examinations, pregnancy, determination of refractive error or similar procedures and studies.

The new programs will help to close the gap in coverage of services that can be safely performed on an outpatient diagnostic basis without the need for hospital admissions for diagnostic purposes.

In a cost-containment direction, it supplements and coincides with the Pre-Admission Testing Program offered by Blue Cross and Blue Shield to limit hospital admissions to those which are medically necessary. PAT enables member-subscribers to get their pre-surgical tests completed on an outpatient basis before elective surgery and prior to hospital admission. The program gives physicians the opportunity to gather necessary medical data on the patient without hospitalization for a day or two before surgery, thus cutting costs while giving the proper care to their patients.

In another area of diagnostics, the American Medical Association is clearly in support of efforts to contain the costs of the delivery of quality medical care through the utilization of independent diagnostic laboratories. The AMA House of Delegates at the 1969 convention adopted the following resolution on utilization of laboratory services. It read as follows:

> RESOLVED, That:
> "(1) It is preferable that the laboratory, not the attending physician, bill and collect from the patient or third party payer for laboratory services. Where circumstances make this impractical or where increased costs to the patient will result, the bill submitted by the attending physician to his patient or third party payer should state the name of the laboratory performing the services for this patient and the exact amount of the charge paid or to be paid by the physician to the laboratory. Medical societies are urged to use all means legally available to them in effecting the foregoing.
> (2) The attending physician is entitled to fair compensation for professional services he renders. He is not engaged in a commercial enterprise, however, and any mark-up, commission or profit on the services rendered by a laboratory is exploitation of the patient.
> (3) In billing patients for laboratory services which attending physicians perform for their own patients, the bill should provide information to show where such services were performed as well as an adequate description of the services provided and the specific charges made."

NOTE: Medicare and other third party payors recognize the justification for the physician to render a nominal charge (e.g. $3.00) to cover his services and supplies when he obtains a specimen to be forwarded to an independent laboratory.

ASK BLUE SHIELD
. . . ABOUT MEDICARE

New Amendments to Part B Medicare Announced

Amendments to the Social Security Act affecting Part B Medicare claimants and physicians were announced by the Department of Health, Education and Welfare late in November. The 1972 amendments were effective on and after October 30, 1972. They include the following:

(1) *Definition of Physician-Optometrist and Coverage of Prosthetic Lenses:* A doctor of optometry, licensed to practice in his state, becomes a "physician" under Medicare for the purpose of prescribing prosthetic lenses. Payment may be made for the lenses whether they are prescribed by an optometrist or a physician authorized to do so.

The amendment does not change the limitation on coverage of optometric services. Refractive services, whether performed by a physician or optometrist, continue to be excluded from coverage. The exclusion of refraction applies whether the total examination is for the treatment or diagnosis of eye disease, injury, or in connection with furnishing prosthetic lenses.

Prosthetic lenses prescribed for post-cataract surgical patients are covered under Medicare. Payments can also be made for any necessary adjustments, repairs or replacements of the lenses.

(2) *Colostomy Bags and Necessary Accouterments Covered Under Prosthetic Devices:* Prior to the new amendment, colostomy bags and necessary accouterments required for attachment were covered under Part B Medicare as Surgical Dressings. The amendment now covers these items under Prosthetic Devices, and extends coverage to irrigation and flushing equipment, and to other items and supplies directly related to colostomy care whether or not the attachment of the bag is required. The amendment applies to supplies purchased after October 30, 1972.

(3) *Limitation on Part B Hearings After Review Action:* A new provision in the 1972 amendment places a $100 minimum limitation on a claimant's privilege to a Part B formal hearing after a review action has been taken on a claim.

A review of the disallowed charges may be requested within six months after receipt of the Explanation of Benefits Form. The request for review must be in writing. If the claimant is dissatisfied with the review determination, he may request a formal hearing if the amount in controversy exceeds $100.

In determining the amount "in controversy," a hearing officer considers the total amount involved arising from the claim or series of claims in the appeal. He decides whether the claim or claims have been adjudicated through the review level and the request(s) for a hearing has been properly filed. The total amount in dispute, less the applicable deductible and co-insurance, is the amount "in controversy." This amount under the new amendment must be $100 or more.

When a Part B Medicare hearing officer receives such a request for a formal hearing, he determines whether the criteria for the $100 minimum has, or has not, been met. If the claim is under $100, he can disallow the request for cause. Part B carriers, however, are required to send all requests for hearings to hearing officers for disposition, regardless of the amount of the claim in question.

Any claimant who had appealed and received a notice of review prior to October 30, 1972 will not be affected by the $100 limitation, and will be granted a hearing regardless of the amount of the claim in dispute.

Limitations on Injections

Injections administered for treatment of a disease which exceed the frequency and duration indicated by "accepted standards of medical practice" as an appropriate level of care for that condition are not covered under Part B Medicare unless there are extenuating circumstances to justify the need for additional injections.

For example, where "standard medical practice" indicates the use of parenteral penicillin or other antibiotics for the initiation of, but not for the entire course of treatment of an infectious disease, the charge for those penicillin injections exceeding the initial standard dosage would be excluded from payment. However, when there were special medical circumstances which justify the additional injections, please indicate the necessity on the SSA 1490, Request for Medicare Payment form or itemized statement.

(This report is a service to the physicians of Illinois)

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(cover by Mike Ahearn)

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REGISTERED AIA MEDIA DATA FORM

In Gonorrhea

Injection WYCILLIN®

(sterile procaine penicillin G suspension) Wyeth

Penicillin in large doses remains the drug of choice in therapy of gonorrhea. Among penicillins, first choice recommended by the national Center for Disease Control for parenteral therapy of uncomplicated gonorrhea is aqueous procaine penicillin G.

Administration of 4.8 million units together with 1 gram oral probenecid, preferably given at least 30 minutes prior to injection, is recommended in treatment of uncomplicated gonorrhea.

Indications: In treatment of moderately severe infections due to penicillin G-sensitive microorganisms sensitive to the low and persistent serum levels common to this particular dosage form. Therapy should be guided by bacteriological studies (including sensitivity tests) and by clinical response.

NOTE: When high sustained serum levels are required use aqueous penicillin G, IM or IV.

The following infection will usually respond to adequate dosages of intramuscular procaine penicillin G.—*N. gonorrhoeae:* acute and chronic (without bacteremia).

FOR DEEP INTRAMUSCULAR INJECTION ONLY.

Contraindications: Previous hypersensitivity reaction to any penicillin.

Warnings: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy.

Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen and intravenous corticosteroids should also be administered as indicated.

Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents e.g., pressor amines, antihistamines and corticosteroids.

Precautions: Use cautiously in individuals with histories of significant allergies and/or asthma.

Carefully avoid intravenous or intraarterial use, or injection into or near major peripheral nerves or blood vessels, since such injections may produce neurovascular damage.

A small percentage of patients are sensitive to procaine. If there is a history of sensitivity, make the usual test: Inject intradermally 0.1 cc. of a 1 to 2 percent procaine solution. Development of an erythema, wheal, flare or eruption indicates procaine sensitivity. Sensitivity should be treated by the usual methods, including barbiturates, and procaine penicillin preparations should not be used. Antihistaminics appear beneficial in treatment of procaine reaction.

The use of antibiotics may result in overgrowth of nonsusceptible organisms. Constant observation of the patient is essential. If new infections due to bacteria or fungi appear during therapy, discontinue penicillin and take appropriate measures.

If allergic reaction occurs, withdraw penicillin unless, in the opinion of the physician, the condition being treated is life threatening and amenable only to penicillin therapy.

When treating gonococcal infections with suspected primary or secondary syphilis, perform proper diagnostic procedures, including darkfield examinations. In all cases in which concomitant syphilis is suspected, perform monthly serological tests for at least four months.

Adverse Reactions: (Penicillin has significant index of sensitization) skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported. (See "Warnings.")

As with other antisyphilitics, Jarisch-Herxheimer reaction has been reported.

Administration and Dosage: Administer only by *deep intramuscular injection,* in upper outer quadrant of buttock. In infants and small children, midlateral aspect of thigh may be preferable. When doses are repeated, vary injection site. Before injection, aspirate to be sure needle bevel is not in blood vessel. If blood appears, remove needle and inject in another site.

Although some isolates of *Neisseria gonorrhoeae* have decreased susceptibility to penicillin, this resistance is relative, not absolute, and penicillin in large doses remains the drug of choice. Physicians are cautioned not to use less than recommended doses.

Gonorrheal infections (uncomplicated)—Men or Women: 4.8 million units intramuscularly divided into at least two doses and injected at different sites at one visit, together with 1 gram of oral probenecid, preferably given at least 30 minutes prior to injection.

NOTE: Treatment of severe complications of gonorrhea should be individualized using large amounts of short-acting penicillin. Gonorrheal endocarditis should be treated intensively with aqueous penicillin G. Prophylactic or epidemiologic treatment for gonorrhea (male and female) is accomplished with same treatment schedules as for uncomplicated gonorrhea.

Retreatment: The National Center for Disease Control, Venereal Disease Branch, U.S. Dept. H.E.W. recommends:

Test cure procedures at approximately 7-14 days after therapy. In the male, a gram-stained smear is adequate if positive; otherwise, a culture specimen should be obtained from the anterior urethra. In the female, culture specimens should be obtained from both the endocervical and anal canal sites.

Retreatment in males is indicated if urethral discharge persists 3 or more days following initial therapy and smear or culture remains positive. Follow-up treatment consists of 4.8 million units. I.M. divided in 2 injection sites at single visit.

In uncomplicated gonorrhea in the female, retreatment is indicated if follow-up cervical or rectal cultures remain positive for *N. gonorrhoeae.* Follow-up treatment consists of 4.8 million units daily on 2 successive days.

Syphilis: all gonorrhea patients should have a serologic test for syphilis at the time of diagnosis. Patients with gonorrhea who also have syphilis should be given additional treatment appropriate to the stage of syphilis.

Composition: Each TUBEX® disposable syringe 2,400,000 units (4-cc. size) contains procaine penicillin G in a stabilized aqueous suspension with sodium citrate buffer, and as w/v approximately 0.7% lecithin, 0.4% carboxymethylcellulose, 0.4% polyvinylpyrrolidone, 0.01% propylparaben and 0.09% methylparaben. The multiple-dose 10-cc. vial contains per cc. 300,000 units procaine penicillin G in a stabilized aqueous suspension with sodium citrate buffer and approximately 7 mg. lecithin, 2 mg. carboxymethylcellulose, 3 mg. polyvinylpyrrolidone, 0.5 mg. sorbitan monopalmitate, 0.5 mg. polyoxyethylene sorbitan monopalmitate, 0.14 mg. propylparaben and 1.2 mg. methylparaben.

Denise has VD.

Let's keep it from getting around.

Actual new cases of infectious syphilis apparently reached the 100,000 mark during the past year; new cases of gonorrhea, more than 2.5 million. That VD is rampant again is due, in large part, to the multiple contacts of teenagers like Denise.

By administering adequate doses of the recommended types of penicillin, you can usually cure VD in the beginning stages. And destroy another link in the chain of infection.

In Syphilis

Injection

BICILLIN® Long-Acting (sterile benzathine penicillin G suspension) Wyeth

Benzathine penicillin G...a drug of choice recommended by the national Center for Disease Control in all stages of syphilis and in preventive treatment after exposure.

Administration of 2.4 million units (1.2 million in each buttock) of benzathine penicillin G usually • cures most cases of primary, secondary and latent syphilis with negative spinal fluid • helps break chain of infection • minimizes chance of immediate reinfection.

Indications: In treatment of infections due to penicillin G-sensitive microorganisms that are susceptible to the low and very prolonged serum levels common to this particular dosage form. Therapy should be guided by bacteriological studies (including sensitivity tests) and by clinical response.

The following infections will usually respond to adequate dosage of intramuscular benzathine penicillin G.—Venereal infections: Syphilis, yaws, bejel and pinta.

FOR DEEP INTRAMUSCULAR INJECTION ONLY.

Contraindications: Previous hypersensitivity reaction to any penicillin.

Warnings: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported. Anaphylaxis is more frequent following parenteral therapy but has occurred with oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens.

Severe hypersensitivity reactions with cephalosporins have been well documented in patients with history of penicillin hypersensitivity. Before penicillin therapy, carefully inquire into previous hypersensitivity to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and treat with usual agents, e.g., pressor amines, antihistamines and corticosteroids.

Precautions: Use cautiously in individuals with histories of significant allergies and/or asthma.

Carefully avoid intravenous or intraarterial use, or injection into or near major peripheral nerves or blood vessels, since such injection may produce neurovascular damage.

In streptococcal infections, therapy must be sufficient to eliminate the organism; otherwise the sequelae of streptococcal disease may occur. Take cultures following completion of treatment to determine whether streptococci have been eradicated.

Prolonged use of antibiotics may promote overgrowth of nonsusceptible organisms including fungi. Take appropriate measures should superinfection occur.

Adverse Reactions: Hypersensitivity reactions reported are skin eruptions (maculopapular to exfoliative dermatitis), urticaria and other serum sickness reactions, laryngeal edema and anaphylaxis. Fever and eosinophilia may frequently be only reaction observed. Hemolytic anemia, leucopenia, thrombocytopenia, neuropathy and nephropathy are infrequent and usually associated with high doses of parenteral penicillin.

As with other antisyphilitics, Jarisch-Herxheimer reaction has been reported.

Administration and Dosage: Venereal infections—

Syphilis—Primary, secondary and latent—2.4 million units (1 dose).

Late (tertiary and neurosyphilis)—2.4 million units at 7 day intervals for three doses.

Congenital—under 2 years of age, 50,000 units/Kg. body weight; ages 2-12 years, adjust dosage based on adult dosage schedule.

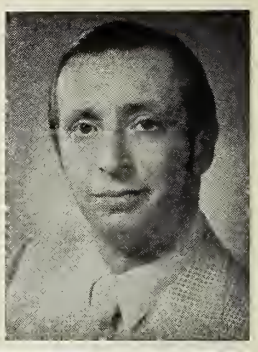
(Shake multiple-dose vial vigorously before withdrawing the desired dose.) Administer by **deep intramuscular injection** in the upper outer quadrant of the buttock. In infants and small children, the midlateral aspect of the thigh may be preferable. When doses are repeated, vary the injection site. Before injecting the dose, aspirate to be sure needle bevel is not in a blood vessel. If blood appears, remove the needle and inject in another site.

Composition: 2,400,000 units in 4-cc single dose disposable syringe. Each TUBEX disposable syringe also contains in aqueous suspension with sodium citrate buffer, as w/v approximately 0.5% lecithin, 0.4% carboxymethylcellulose, 0.4% polyvinylpyrrolidone, 0.01% propylparaben and 0.09% methylparaben. Units benzathine penicillin G (as active ingredient), 300,000 units per cc—10-cc. multi-dose vial. Each cc also contains sodium citrate buffer, approximately 6 mg. lecithin, 3 mg. polyvinylpyrrolidone, 1 mg. carboxymethylcellulose, 0.5 mg. sorbitan monopalmitate, 0.5 mg. polyoxyethylene sorbitan monopalmitate, 0.14 mg. propylparaben and 1.2 mg. methylparaben.

Wyeth Laboratories · Philadelphia, Pa. 19101



the presidents page



If We Ever Needed Unity . . . It Is Now

Professional Standards Review Organization (PSRO) . . . like it or not . . . it's here. The question is . . . What are we going to do about it?

Naturally, there are thousands of unanswered questions concerning both how the new law will work and the line of action we physicians should take.

But don't count on getting simple or straightforward answers anytime soon. It seems this little piece of legislation raised more questions than it answered.

As I see it, we have three alternatives. One, ignore it . . . pretend that the law doesn't exist. Two, fight it . . . anyone want to wage a war against HEW? Three, give the program our input . . . work with HEW to formulate the guidelines and help develop the rules and regulations which will govern the Professional Standards Review Organization.

I believe the choice is obvious. PSRO IS LAW . . . nothing is going to change that.

Granted, the majority of we physicians did not want PSRO's. I myself still wonder whether a government operated program of mandatory peer review can be aimed at cost control and still not effect the quality of patient care. But that answer will only come with time.

Now, more than ever, we must unite and present a strong and unified voice to HEW and all other government agencies. This program, and our reactions to it, will strongly influence not only the course of PSRO's . . . but ultimately, the destiny of medicine in America.

If we splinter now, what will we use as our bargaining lever?

HEW will no doubt prepare stacks of position papers, solicit opinions from hither and yon and possibly even hold public hearings . . . all before a single regulation goes down on paper.

HEW will need outside input to pull this program together and establish workable PSRO rules and regulations. For our own sake, and more importantly, for the sake of our patients, I hope that it is PHYSICIAN input . . . OUR input. And there is no reason why it shouldn't be.

Just how long will it take to get the PSRO program rolling? One of HEW's still scarce experts guesses that no more than 12 of the new peer review organizations will be functioning within a year after the 150 to 250 PSRO areas are designated.

The problem lies in the fact that the majority of our health care providers simply don't understand the entire PSRO concept. Nor do they know how to begin implementation of the program.

This is why we must make HEW realize the importance of cost accountability instead of gross standardizations. Through development of pilot programs, we could derive this information and avoid many of the problems we encountered with the Medicare/Medicaid programs.

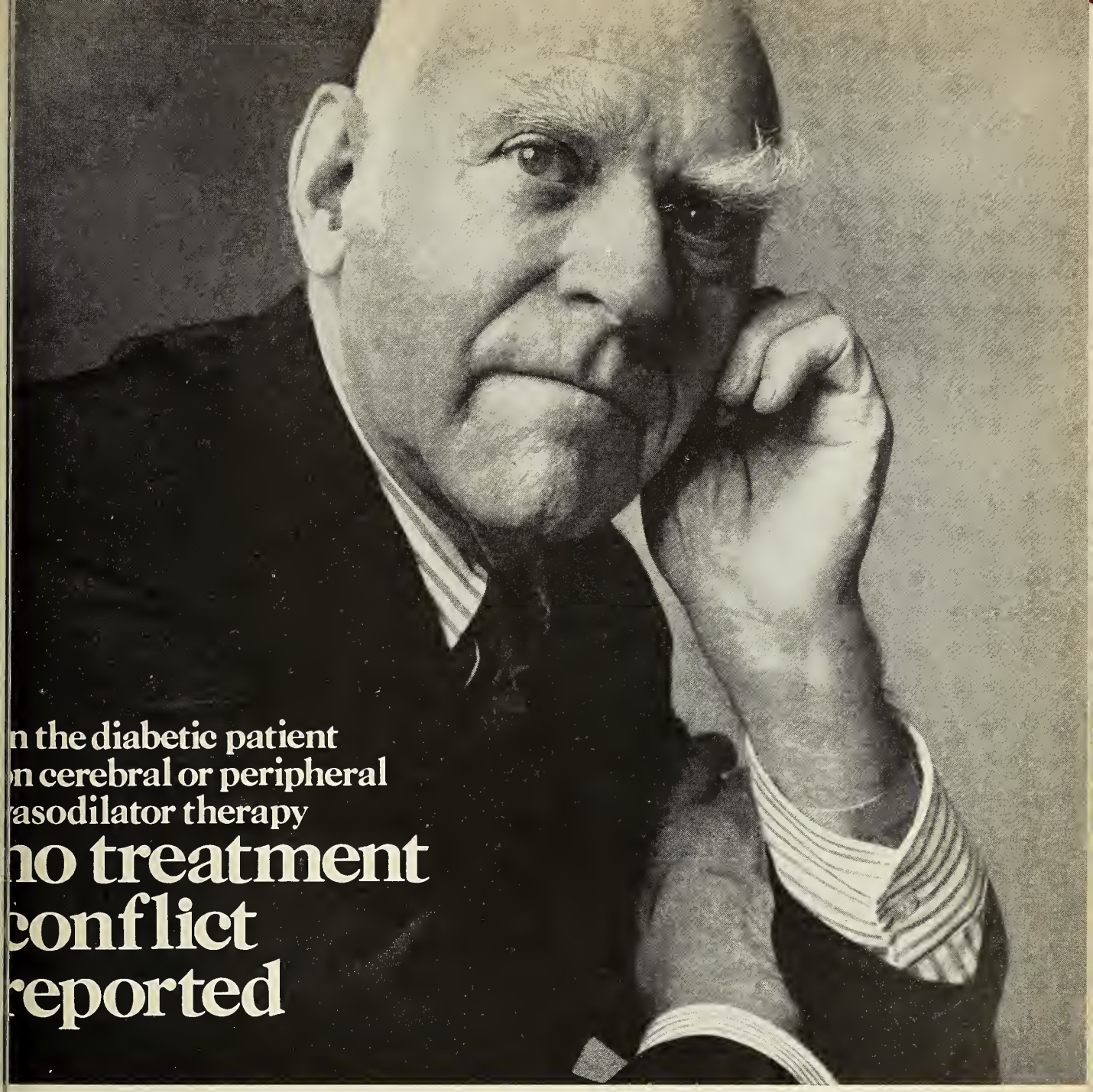
ISMS has this working knowledge. We are in a position to help other regions establish their programs.

But all of these things will not be accomplished through individuals standing alone.

ISMS needs your support . . . physically, mentally, financially. Let's be sure that PSRO's are developed, managed and altered with the maximum of physician input.

If ever we needed unity . . . it is now.

Frank J. Jirka, Jr. M.D.



n the diabetic patient
n cerebral or peripheral
asodilator therapy
no treatment
conflict
reported

VASODILAN®
(ISOXSUPRINE HCl)
he compatible vasodilator

- no interference with diabetic control . . . does not alter carbohydrate metabolism.[1]
- conflicts have not been reported with diuretics, corticosteroids, antihypertensives or miotics.

There are no known contraindications in recommended oral doses other than it should not be given in the presence of frank arterial bleeding or immediately postpartum.

INDICATIONS: Based on a review of this drug by the National Academy of Sciences–National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1 the relief of symptoms associated with cerebral vascular insufficiency.

eripheral vascular disease of arteriosclerosis obliterans, hoangiitis obliterans (Buerger's disease) and Raynaud's disease.

ned abortion.

fication of the less-than-effective indications requires further

Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

& COMPANY • EVANSVILLE, INDIANA 47721 U.S.A. 10372

DOSAGE AND ADMINISTRATION: 10 to 20 mg. three or four times daily.

CONTRAINDICATIONS AND CAUTIONS: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

ADVERSE REACTIONS: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

SUPPLIED:
Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose
20 mg.—bottles of 100, 500 and Unit Dose

REFERENCE: 1. Samuels, S. S., and Shaftel, H. E.: J. Indiana Med. Ass. *54*:1021-1023 (July) 1961.

Mead Johnson LABORATORIES

Twenty-Seven Clinics For Crippled Children Slated For February

Twenty-seven clinics for Illinois' physically handicapped children have been scheduled for February by the University of Illinois, Division of Services for Crippled Children. The Division will conduct 19 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social, and nursing services. There will be six special clinics for children with cardiac conditions, and two for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

February 1 Lake County Cardiac—Victory Memorial Hospital
February 1 Sterling—Sterling Community Hospital
February 5 Peoria Cardiac—St. Francis Children's Hospital
February 7 Hinsdale—Hinsdale Sanitarium
February 8 Rockford—St. Anthony Hospital
February 8 Springfield—St. John's Hospital
February 8 Anna—Union County Hospital
February 8 Flora—Clay County Hospital
February 9 Chicago Heights Cardiac—St. James Hospital
February 13 E. St. Louis—Christian Welfare Hospital
February 13 Peoria—St. Francis Children's Hospital
February 14 Rock Island Cerebral Palsy—Foundation for Crippled Children and Adults
February 14 Champaign-Urbana—McKinley Hospital
February 14 Carlinville—Carlinville Area Hospital
February 15 Elmhurst Cardiac—Memorial Hospital of DuPage County
February 15 Bloomington—Mennonite Hospital
February 19 Peoria Cardiac—St. Francis Children's Hospital
February 20 Rock Island—Moline Public Hospital
February 20 Belleville—St. Elizabeth's Hospital
February 21 Chicago Heights General—St. James Hospital
February 22 Kankakee—St. Mary's Hospital
February 23 Chicago Heights Cardiac—St. James Hospital

(Continued on page 39)

reliable pain relief without codeine.

Percodan® C II

Each yellow, scored tablet contains 4.50 mg. oxycodone HCl (Warning: May be habit-forming), 0.38 mg. oxycodone terephthalate (Warning: May be habit-forming), 224 mg. aspirin, 160 mg. phenacetin, and 32 mg. caffeine.

INDICATIONS: For the relief of moderate to moderately severe pain.
CONTRAINDICATIONS: Hypersensitivity to oxycodone, aspirin, phenacetin or caffeine.
WARNINGS: *Drug Dependence:* Oxycodone can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Psychic dependence, physical dependence and tolerance may develop upon repeated administration of Percodan, and it should be prescribed and administered with the same degree of caution appropriate to the use of other oral narcotic-containing medications. Like other narcotic-containing medications, Percodan is subject to the Federal Controlled Substances Act.
Usage in ambulatory patients: Oxycodone may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient using Percodan should be cautioned accordingly.
Interaction with other central nervous system depressants: Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics or other CNS depressants (including alcohol) concomitantly with Percodan may exhibit an additive CNS depression. When such combined therapy is contemplated, the dose of one or both agents should be reduced.
Usage in pregnancy: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, Percodan should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.
Usage in children: Percodan should not be administered to children.
Salicylates should be used with caution in the presence of peptic ulcer or coagulation abnormalities.
PRECAUTIONS: *Head injury and increased intracranial pressure:* The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.
Acute abdominal conditions: The administration of Percodan or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.
Special risk patients: Percodan should be given with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, and prostatic hypertrophy or urethral stricture.
Phenacetin has been reported to damage the kidneys when taken in excessive amounts for a long time.
ADVERSE REACTIONS: The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. Some of these adverse reactions may be alleviated if the patient lies down.
Other adverse reactions include euphoria, dysphoria, constipation and pruritus.
DOSAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. It may occasionally be necessary to exceed the usual dosage recommended below in cases of more severe pain or in those patients who have become tolerant to the analgesic effect of narcotics. The usual adult dose is one tablet every six hours as needed for pain.
DRUG INTERACTIONS: The CNS depressant effects of Percodan may be additive with that of other CNS depressants. See WARNINGS.
Aspirin may enhance the effect of anticoagulants and inhibit the effect of uricosuric agents.
MANAGEMENT OF OVERDOSAGE: *Signs and Symptoms:* Serious overdose with Percodan is characterized by respiratory depression, extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. In severe overdosage, apnea, circulatory collapse, cardiac arrest and death may occur. The ingestion of very large amounts of Percodan may, in addition, result in acute salicylate intoxication.
Treatment: Primary attention should be given to the re-establishment of adequate respiratory exchange through provision of a patent airway and the institution of assisted or controlled ventilation. The narcotic antagonists naloxone, nalorphine or levallorphan are specific antidotes against respiratory depression which may result from overdosage or unusual sensitivity to narcotics, including oxycodone. Therefore, an appropriate dose of one of these antagonists should be administered, preferably by the intravenous route, simultaneously with efforts at respiratory resuscitation. Since the duration of action of oxycodone may exceed that of the antagonist, the patient should be kept under continued surveillance and repeated doses of the antagonist should be administered as needed to maintain adequate respiration.
An antagonist should not be administered in the absence of clinically significant respiratory or cardiovascular depression.
Oxygen, intravenous fluids, vasopressors and other supportive measures should be employed as indicated.
Gastric emptying may be useful in removing unabsorbed drug.

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During anginal attacks, patients may suffer intense apprehension. More frequently, however, they experience a continuing sense of less severe but nonetheless disproportionate anxiety.

Reduction of such clinically significant anxiety is important, since undue emotional stress may precipitate further anginal episodes.

Adjunctive Librium (chlordiazepoxide HCl) may be especially suitable for relief of clinically significant anxiety and emotional tension in anginal patients because of its generally prompt therapeutic effectiveness and wide margin of safety. In a recent double-blind randomized study,* Librium (chlordiazepoxide HCl) was administered for relief of moderate anxiety in 20 anginal patients seen in office practice over a 20-week period. Symptoms of emotional distress related to anxiety were rated at base-line, one week, two weeks and monthly thereafter. Relief was obtained notably early in therapy. The clinical results demonstrated that Librium offers the coronary patient an antianxiety drug that, in the author's opinion, is both effective and safe. In general use, the most common side effects reported have been drowsiness, ataxia and confusion, particularly in the elderly and debilitated. (See summary of prescribing information.)

Librium (chlordiazepoxide HCl) is used concomitantly with certain specific medications of other classes of drugs, such as cardiac glycosides, diuretics and antihypertensive agents, whenever anxiety is clinically significant. The drug should be discontinued after anxiety has been reduced to appropriate levels.

The positive power of adjunctive Librium® (chlordiazepoxide HCl)

10-mg, 25-mg capsules up to 100 mg daily

for moderate to severe anxiety accompanying angina pectoris

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Supplied: Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

*Levine, S.: "Angina Pectoris and Emotional Overlay," Scientific Exhibit presented at the Annual Meeting of the Maine Medical Association, Kennebunkport, Me., June 13-15, 1971.

A copy of the Levine study may be obtained from your Roche representative.

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editorials

Carrots are better than sticks

Rittelmeyer[1] recently stressed the need for the physician to recognize certain traits in his patients in order to promote satisfactory recovery. Personality determines an individual's reaction to sickness. The dependent, demanding person, for example, insists upon detailed explanations. He monopolizes the doctor's time and may become obnoxious to physicians and nurses. When ill, he is likely to develop feelings of helplessness and a fear of abandonment. Actually, he needs emotional support and assurance, but limits on his demands must be established.

The orderly, controlled personality wants to know all details of his medical condition. He thrives on self-discipline, almost to the point of being compulsive. Illness to him means a loss of control over his own impulses, a lessening of productivity and anxiety. He wants to know what plans have been made for therapy. Surgery or a major illness throws these stalwarts into a spin.

We are all familiar with the type who enjoys poor health and self-imposed martyrdom. Usually a woman, she has a history of repeated illnesses and multiple hospitalizations for obscure conditions. Be sympathetic, but do not prescribe unnecessary drugs or recommend operations of doubtful necessity. According to Rittelmeyer, telling her that she will soon be feeling better usually makes her feel worse.

Rittelmeyer mentions the four general rules of Parsons and Fox for establishing a successful doctor-patient relationship. The first is permissiveness. This means allowing the patient to express his ideas, feelings, and fantasies—no matter how strange they may appear. "After all, the doctor is a healer, not a judge."

The second rule is that the physician should lend support. "This is more than merely accepting and respecting the details of the patient's troubles; it also involves valuing him as a person with all his incapacities, his complaints and his demands." There is a limit to how far this should be allowed to go but avoid hostility and punitive motives. The third rule is to introduce conditional rewards for following the advice of the physician. "The carrot is not only more humane than the stick but also more effective."

The fourth rule is that the physician should "adhere scrupulously to a professional attitude, despite the patient's inclination either to demand too much involvement by the physician or to push him away." And finally, always be alert to the patient's mood and behavior.

T. R. Van Dellen, M.D.
Editor

[1] Louis F. Rittelmeyer, Jr.: "Therapeutic Use of the Doctor-Patient Relationship," *Amer. Family Phys.*, 4:103, (July), 1971.

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Role of the Psychiatric Consultant at a Rehabilitative Agency

By Ronald Shlensky, M.D./Chicago

For one year I was the psychiatric consultant to a multidimensional agency for rehabilitation of the blind. This paper deals with my role there and the problems associated with such a role for a psychiatrist. The observations herein are based on my experiences there and in other community consultative roles.

Services to Whom

A major question arising in such a situation is toward whom the consultant's services should be directed, clients or staff? The answer is not simple. The consultant faces pressures which are sometimes contradictory in nature.

Administration, for example, may clearly expect a consultant to provide services to the staff. Particularly at first, however, the staff may feel quite threatened by such an arrangement. A common way for staff to handle that threat is to introduce the client between themselves and the consultant. The latter must recognize this and handle it gently. He himself will feel internal pressures to move in that very direction toward the psychiatric posture. To serve the clients rather than primarily the staff is to fall short of the potential gain for the agency from the consultation. I believe the agency is the consultant's client and should be the object of his efforts.

Inter-Staff Tension

There are always conflicts within the staff group of a professional agency. The consultant will experience many efforts to swing him to a particular side of a controversy or to join a certain faction. Such alignment can only constrict his potential effectiveness. He must hear the statements made to him as expressions of feelings and wishes, rather than manipulations. He must respond with acceptance and understanding. Above all, he must maintain absolute and multi-lateral confidentiality. Finally, he must remain neutral—available to all.

Supervisor vs. Therapist

A classical question arising in the setting of an agency is *where to draw the line between therapy and supervision.* The consultant has individual contact, both formal and informal, with staff members. It is entirely proper and profitable that he never relinquish his identity as consultant in any of these contacts—no matter how informal or at what level of staff authority. But, he must know *where to draw the line between therapy and supervision.* Staff members are inclined to discuss their personal conflicts with the consultant—indeed their personal problems may bear in an important way on their work. However, to allow staff members to function as individual therapy patients within the relationship with the consultant is a grave error on the consultant's part. Such a course of action will breed disappointment and hostility—for in actuality the consultant cannot provide therapy. His duty is to the agency as a whole. He must see to it that the focus of his work with individual staff members is on the agency and its function, not on personal problems. In fact, care about this can and should be therapeutic to the individual staff members. It is not necessary to tread in inappropriate areas. The agency is not paying for treatment for its individual staff members, but rather for preventive psychiatric measures for its staff and clients. Helping staff members to do a better job, to understand clients, to generate an attitude of ac-

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ceptance and open expression of feelings in a constructive way is to be very therapeutic without biting off more than one can chew.

Educator

In several ways pressure is brought to bear upon a consultant to educate. A fairly consistent feature of an agency's format for consultation is the weekly staff meeting. This seems to be rather a central event in the ongoing agency-consultant relationship and is thus a potential nidus of much tension. Both the staff and the consultant have mixed feelings about this meeting. It can be stimulating and warm or frustrating and tense. It will probably be both of these at one time or another.

Often the consultant (somehow) becomes a part-time lecturer to this group. This may be good or bad or both. An essential question seems to be whether this is a bona fide means of furthering the staff's psychological sophistication or a defensive operation, employed by both the staff and the consultant to avoid more threatening but potentially more useful issues. Again the answer may be both at one time or another, but the consultant and the group must be able to recognize which and when. This requires open and free minded communication.

Confidentiality

1. Contacts with individual clients.

In general the classical rules of confidentiality should apply. However problems arise. The entire agency staff may be working with a client and wish help from the consultant. Other staff members may feel rejected or depreciated by the consultant's unwillingness to share information.

The consultant should stick to his guns and not share information given to him by the client. Eventually, I believe, the staff will come to accept and appreciate this. It will also enhance their trust of the consultant.

This does not mean, however, that the consultant is not able to share his own thoughts and feelings about the client with staff. That is not a violation of confidentiality, and is necessary if the consultant is to help staff deal with a problematic client.

2. Contacts with individual staff members.

Here absolute confidentiality is vital. There should be no exceptions. Even the sharing of thoughts and feelings regarding a staff member are best avoided by the consultant.

3. Contact with administrators.

Administrators want to help in dealing with their staff. They sometimes feel that the consultant should evaluate a staff member and give administration a report. I oppose this practice. It is counter to all psychiatric principles and can only generate distrust.

4. In quasi social relationships with other staff.

A consultant cannot step out of his role for a moment or his effectiveness suffers. Some staff hope to gain reassurance and support by relating to the consultant outside of the professional context. My view is that a doctor cannot (somehow) stop being a doctor temporarily and that the same applies to a consultant. To do so is to erode effectiveness.

5. Group confidentiality.

The duty of confidentiality to the agency as a whole cannot be over emphasized. Comments regarding the agency to other areas of the community, positive or critical, are inappropriate and negatively reflect upon the consultant's competency. Here the analogy of the agency as a patient is particularly cogent.

Summary

I see the psychiatric consultant as a physician to an agency. His job is to help the agency to deal with its problems. He must be gentle, kind, non-judgmental, accepting, understanding, trustworthy and available. He must avoid faction favoritism—that is, he cannot allow himself to be used by one faction against another. Sticking closely to general psychiatric principles will serve him in good stead when no better structure is available. ◄

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Roundup

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See Details on Page 20

The Rockford School of Medicine -- What it is and What it Does

By Robert L. Evans, M.D.
Dean, Rockford School of Medicine, College of Medicine, University of Illinois

It is the purpose of this paper to provide broad review of the concept of the Rockford School of Medicine, University of Illinois College of Medicine. Because of its general nature, this description will include at least something on each of the operational facets of the Rockford School of Medicine (RSM). To gather a detailed view it will be necessary to request the written material which is available for each specific program.

What is RSM?

The Rockford School of Medicine (RSM) is a school of the University of Illinois College of Medicine. The University of Illinois is one of the nation's major state Universities and has three units. Two of these campuses (at Urbana-Champaign and Chicago Circle) are composed of both undergraduate and graduate schools in the arts, sciences and professions. The third campus, the Medical Center Campus, comprises those schools that are health-care related and which are involved with the production of health professionals. These are the Schools and Colleges of Public Health, Pharmacy, Nursing, Dentistry, and Medicine.

The University of Illinois College of Medicine is composed of six schools. Five of the six schools are related directly to physician education. The sixth is the School of Associated Medical Sciences (SAMS), which operates programs for the technical and professional education of many individuals other than physicians and nurses.

Of the remaining five schools of the College of Medicine, two, located at the Medical Center Campus, Chicago, and at the Urbana-Champaign campus, are schools of Basic Medical Science. These schools have the mission of providing a one-year curriculum primarily involving anatomy, biochemistry, physiology, and with varying amounts of pharmacology, pathology, and microbiology.

The remaining three schools of the College of Medicine are medical schools designed for a three-year learning experience in clinical medicine. These are: The Abraham Lincoln School of Medicine (at the Medical Center, Chicago), the Peoria School of Medicine, and the Rockford School of Medicine (RSM).

The RSM was organized in May, 1971, by action of the Board of Trustees of the University of Illinois. Its overall purposes are in keeping with the "Report on Health Education" rendered to the State Board of Higher Education in 1967. Rockford and Peoria are schools designed to move medical education outside the metropolitan area of Chicago, specifically, to retain more physicians within the state and to begin to alleviate the "maldistribution" of physicians within Illinois. The secondary goal is to build functional medical education institutions utilizing the already constructed clinical facilities of the communities, thus realizing a considerable saving in capital expense and a clear-cut community identity for the school.

From the first it has been the purpose of the Rockford School of Medicine to have clear community identification. It is planned to be viewed by Rockford as a community function, operated through the expertise and capability of the University of Illinois, rather than being identified as a unit of the University which is simply located in Rockford.

Goals of the Rockford School of Medicine

In Regard to Students:

1. See a need for, and work towards, prevention of human illness while being responsible for its recognition and healing, and the relief of suffering.
2. Maintain flexibility of career choice for as long as possible, while obtaining the breadth of experience needed to com-



Robert L. Evans, M.D., has served as Dean of the Rockford School of Medicine since 1971 and is also Professor of Medicine. Dr. Evans has served on the President's Commission on Health Manpower and served as president of the Association for Hospital Medical Education. He is presently serving on the Board of Trustees at Thomas Jefferson University (Jefferson Medical College), Philadelphia, Pa., and is on the Board of Directors for the Educational Council for Foreign Medical Graduates. Dr. Evans received his medical degree from Jefferson Medical College, Philadelphia, Pa.

pare opportunities in the many fields of clinical medicine, education in medicine, and research.

3. Acquire a thirst for continuing education as the inseparable companion to the privilege of decision-making in regard to health care of other humans.

In Regard to Faculty:

1. To involve the practicing physicians of the community, and the support faculty, deeply in the organization and function of the School of Medicine—and to provide a continuously evident practicing-physician role-model for the student.
2. To create in the physician-teacher the same deep feeling of responsibility for the individual student's education that he has for his patient care, thus assuring his involvement.
3. To provide continuing education in both education and medicine for the teachers of the Rockford School of Medicine; to aim both programs at measured and demonstrated need and practice patterns.

In Regard to the Community:

1. To complement and to extend the capability and sophistication of the medical services and medical personnel available to the community.
2. To serve as one means of providing additional physicians to the state and to the area surrounding Rockford and thus correct both the shortage and "maldistribution" of physicians in north-central and northwestern Illinois.
3. To efficiently utilize the investment of the community in its present medical care facilities and in the process to improve the quality and quantity of care.

In Relation to All of the Above:

To provide a system of constant evaluation of goal, objective, process, and product so that information concerning the individual capabilities of students, faculty, curriculum, and community institutions is made constantly available to the medical care and service system in which the Rockford School of Medicine is immersed. This is a major service to the area.

The Rockford Community

The city of Rockford has a census population of 147,400. Its service area encompasses approximately 350,000 people. Rockford is a major manufacturing center which has broadly diverse and highly sophisticated industry. Its primary products are machine tools, fasteners, and aircraft systems and support mechanisms.

Rockford's general hospitals are Rockford Memorial, St. Anthony, and Swedish-American, totaling approximately 1,000 beds. There is also the H. Douglas Singer Zone Center, a state mental health facility serving Region 1A (the nine counties in northwestern Illinois), and having 250 acute shortstay psychiatric beds and facilities for the outpatient care of approximately 1,000 patients on a continuing basis.

A formal "Memorandum of Understanding" exists between the hospitals, Zone center, and the University of Illinois, as represented by the Rockford School of Medicine. The memorandum is a simple document which states the rights of each of the four units and establishes clearly the role of the fifth body, the Rockford Medical Education Foundation.

The Rockford Medical Education Foundation (RMEF)

The RMEF was originally established by the Community Hospital Council of Rockford as a committee with the primary purpose of smoothing the way and shortening the time for the establishment of a school of medicine in Rockford. The foundation considered its work at an end with the establishment of the school and the appointment of the Dean in mid-1971. The Dean and the leadership of the foundation, however, soon identified the RMEF as a major force in medical education in the community. Specifically, it is an answer to providing community "stewardship" for the graduate and continuing education programs, inseparable companions to good undergraduate medical education. With these thoughts in mind RMEF was reorganized.

As reorganized, the Foundation Board is constituted by three individuals from each of the hospitals and the Zone Center (the administrator, a member of the staff, and a member of the board). To this group were added representatives of education, law, clergy, labor, industry, and government.

Programs of graduate education conducted within the community are accredited to the RMEF and are listed as being conducted by, "the Rockford Medical Education Foundation, the Rockford School of Medicine, and their Associated Hospitals."

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This arrangement guarantees to the community that it has "ownership" of the graduate programs and can direct a change in the overall function or management of the programs. At the same time, the RMEF contracts with the Rockford School of Medicine for the operation of the programs, and thus gives the RSM complete authority under the contract. This process removes any institutional identification from the graduate programs so that they do not serve as points of rivalry or discord between the community's medical care institutions.

As an example, the Family Practice Residency was accredited to the RMEF in December of 1971. It is designed for nine residents in each of three years. The assistant dean for administrative affairs serves as Comptroller of the RMEF and supervises the collection of payroll monies from the hospitals (according to the number of Residents/months each hospital has received during the prior month). The office for Family Practice is located in the Medical School building, and it pays to the Foundation its fair share of money (representing Resident time spent in the office). Since the time in the office increases over the three years, this share is about 10% in the first year with an increase to 90% in the third year.

Since the hospitals *do not* include salary for the time Residents spend *in the office* in their cost formulae (Part A), it is proper for the office to bill for Resident care under the direction of the Professor of Family Medicine and his staff. There is no intimation of "double billing" under Part B.

The Rockford Medical Education Foundation serves to promote the community's stewardship of Residency programs, while at the same time providing the school with freedom of action in regard to program direction. Its service as the payroll agency for the residencies is extremely valuable in separating and delineating education and service functions.

Excellent communication exists between all the institutions involved in medical education and higher education within the Rockford area. The dean sits with the board of each of the three voluntary hospitals and the Board of the Winnebago County Medical Society. He or his representative attend the majority of the executive committee meetings of the hospital staffs. There is a monthly meeting of the administrators and medical directors or chiefs of staff of the three hospitals with the dean, the associate dean for hospital programs, and the assistant dean for administrative affairs. The assistant dean sits as a member of the Board of the Comprehensive Health Planning (B) Agency. Thus, there is broad opportunity for discussion of the programs of the RSM with the health care institutions. This creates a sense of common understanding and common goals.

Undergraduate Program

The curriculum of the RSM is a three year continuum designed to take the place of second, third, and fourth years of the more conventionally oriented medical school.

If one considers the average student's week to be divisible into eleven half-day periods (including Saturday mornings), one may conceptualize the division of student time in the first two years of the Rockford curriculum. The diagram below illustrates this general division.

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
BPE*	**IST****	**BPE**	**CHC**	**BPE**	**BPE and/or CHC**
CHC***	**BPE**	**IST**	**BPE**	**BPE**	

**BPE—Basic Professional Experience (See Text)*
***IST—Independent Study Time*
****CHC—Assignment to Community Health Center*

The first two years of the curriculum (consisting of BPE's) divide into two periods: the first begins approximately September 5th and continues through November 30th. The student is involved in an initial orientation period (one week) followed by specific curriculum segments. These first three months serve to give the student an understanding of the problem oriented record. Formal (and quite traditional) lecture and laboratory courses of short duration covering anatomical pathology, normal roentgenology, and clinical pharmacology also are administered during the first three months. This provides the student with the vocabulary and minimal knowledge to allow him to communicate competently with the practicing physicians who will be his teachers for the subsequent 19 months. This 19 months (from December 1st to June 30th of the second subsequent year) is comprised of 16 Basic Professional Experiences (BPE).

The knowledge content of each BPE is determined by a separate curriculum subsegment committee of practicing faculty representing the appropriate clinical and basic sciences. The methodology of teaching of the content is determined by the individual teacher. For example: the six cardiologists in the community are responsible for determining the content necessary to provide the student with the basic cardiology that he needs to perform as anything *other than* an internist, pediatrician, or cardiologist.

Each of the six cardiologists, moreover, will be individually responsible for teaching one student at any single time for an 8 week BPE. He will be responsible for student activity during six half-days of each week (noted as "BPE" on the schedule above). It is expected that the teacher will plan the student's learning activities during these six half-days, the teacher will spend six hours weekly with the student as a minimum personal contact, during which he will review and evaluate with the student the student's experiences in the program, his learning accomplishments, and his progress. A similar design program was utilized for each of the other 15 Basic Professional Experiences. These combine with a total of ten weeks vacation to constitute the first 22 months of medical education at RSM.

In the Community Health Center assignment (two half-days weekly) the student enters actively into the provision of Continuing Comprehensive Personal Health Care in a community. The Centers are offices designed explicitly for student teaching, and staffed permanently by at least two full-time faculty (internists, pediatricians, or family physicians) who are certified in their field. Each office is located in a town which has too few physicians or none and is within 30 minutes drive of RSM. Each Health Center provides continuing care for a community, and provides continuity in patient assignment for the students, since they are assigned to the same unit for their entire time at RSM. Two students are present any given half-day, for a total of ten students assigned to each office faculty "team." This assignment begins in the sophomore year, and continues into the junior and senior years, so that the student develops an indentifiable "practice," always under faculty supervision. All units utilize Problem Oriented Records, terminal digit filing, full laboratory facilities, and dictated records. Some have X-ray facilities of an emergency nature.

The teaching physicians belong to the appropriate county medical society. Indeed, the county societies involved helped RSM to identify those communities in which the centers operate or will be built. Kirkland and Belvidere are now operating, and represent the first two of a total of fifteen centers.

The final year is designed to function as a first year of residency in each of eight possible areas. These are: medicine, family medicine, pediatrics, obstetrics, gynecology, surgery, psychiatry, pathology, and a rotating (undecided) program. In this senior year the student functions as a house staff officer on a continuing basis in one or more of the three hospitals. Specifically, the student has responsibility for patient care, and thus for the judgments rendered in providing patient care, under the direction of the admitting faculty member.

It is a methodologic goal of these three years of undergraduate curriculum to provide: 1) that the faculty feels a sense of total responsibility for student education, akin to the total responsibility which they feel and respond to in the care of their patients, 2) to immerse the student and faculty together in milieu of patient care, with constant evaluation of the educational process as it involves them both.

Graduate Education

Since it is the goal of the Rockford School of Medicine to produce practicing physicians in all of their varied and specialty plumage, the major residency programs in the categories noted for the senior year above will be conducted within the community. If there is an identified need for such programs and if conditions permit, subspecialty programs in several areas will become available as soon as practicable. At present, the programs in family medicine and pathology are established with other residencies being in operation upon the advent of the first senior class.

Continuing Education

The continuing education effort of the Rockford School of Medicine consists of two major areas for function. There is a system of criteria audit, which is functional in each of the three hospitals, and which provides an internal staff evaluation of quality of patient care and physician involvement. This is combined with a system of individual chart audit and criteria audit by students and faculty in the Community Health Centers to provide continuing information as to quality of patient care within the system, and to have the students "live" with such peer evaluation from their earliest experience. The information obtained also can be used to structure continuing education programs on a basis of identified need relative to patient care requirements and physician practice.

The second area is the individual practice profile system (similar to that of Meyer and Sivertson at the University of Wisconsin) which provides individual physician programs for continuing education on a meaningful pre-test, post-test and identified program need status. This utilizes computer based testing, and the "crib" and "case' programs at the Medical Center.

Evaluation

The internal educational evaluation of the Rockford School of Medicine is largely anecdotal, with identified parameters and check lists. It is the goal of this system to identify individual student competence rather than to provide ranking of students within a group. The end-point is accomplishment and demonstrated capability, *not time.*

The continuing education program evaluations discussed earlier, combined with a special unit called the Office for Community Health Research (OCHR), give an in-depth understanding of patient care need and function within the service area of the Rockford medical community. The OCHR is staffed by doctorate level demographers, sociologists, biostatisticians and related personnel. Their charge is to establish a base line of medical care, referral patterns, fiscal, and social information within the service area. Upon this base is built a measurement system which identifies what changes occur as a result of the activities of the School and its educational systems. This is the "compass" which gives directive information for future development.

OCHR is the first operating program in the United States designed to carefully measure what changes are produced by a sophisticated system of medical education and a medical school in a community where no such system has existed previously.

Funding

The capital investment of the Rockford School of Medicine will total less than $10,000,000, including all present building and necessary additions. RSM is designed to produce 75 to 100 physicians yearly for about 35% to 45% of the national average yearly costs. The decreased capital expenditures are the result of the utilization of the community's already constructed clinical facilities. Operating savings are evident due to the availability of institutions and the smaller faculty need with a lower faculty-student ratio. However, the number of hours of individual faculty-student contact instruction is remarkably high, approximately ten times that of most schools.

Summary

The Rockford School of Medicine represents two basic concepts that are new to medical schools and medical education. The first concept originated with the University of Illinois College of Medicine, with the development of schools of medicine as part of the college; they are located in communities and utilize community physicians for the majority of the teaching effort and thus carry a continuing identification with the community. Final certification is by the college.

The second concept is singular to the Rockford School of Medicine and to its operation. This is the goal of "total immersion" of the student and the faculty in a functioning system of medical care delivery encompassing private practice, group practice, model private office units and community health centers. The community health centers combine an opportunity to begin to correct the "maldistribution" of physicians, and to provide students with basic and advanced ambulatory care experience in a setting which stresses comprehensive, continuing personal health care. These units have a deep and meaningful identification with both the patient and the patient's community.

With final certification conducted by the University of Illinois College of Medicine, and with the internal evaluation of the school itself, the concept and product of the Rockford School of Medicine will be constantly evaluated against traditional forms of education in medicine and against curricula representing a melding of both the old and new. We at RSM feel that it will be an extraordinarily productive experience, for the student, for the faculty, and for the people we serve. ◄

Medical Schools Report Continued Growth

Significant increases in numbers of medical schools and in total enrollments of all medical schools were again reported during the 1971-72 school year. Preliminary figures indicate the total will be even greater for the current academic year.

The statistics are included in the 72nd annual report on medical education prepared under auspices of the Council on Medical Education of the American Medical Association, and published in the November 20, 1972, issue of the *Journal of the American Medical Association.*

First-year enrollment in 1971 increased by 1,013 to 12,361. Total enrollment was 43,650, an increase of 3,163 students over the previous academic year.

The increase was achieved both by opening new schools and by expanding enrollment at many of the existing schools. Total number of medical schools in the fall of 1971 was 108. Three new medical schools opened in September, 1972; another will open in January, 1973, and still another in June, 1973, for a total of 113 by the end of the 1972-73 academic year.

Relevance in Teaching Basic Medical Sciences — Preliminary Report of an Approach to Innovation

By Daniel K. Bloomfield, M.D., Thomas E. Gamble, Ed.M., William Sorlie, M.A., and John D. Anderson, Ph.D./University of Illinois, Urbana

Many American medical schools are currently involved in changes of curriculum. The "Flexner Model" of medical education[1] is under strong attack from a direction it has assiduously tried to demonstrate as invalid, the clinical impression. It is ironic that in 1972 this model, despite its emphasis on scientific method, and still producing high quality medical education, leaves the impression that it is deficient in its achievement.[2,3]

The University of Illinois College of Medicine's School of Basic Medical Sciences-Urbana has embarked on a program that superficially seems the antithesis of the Flexner Model but, in actual fact, is a program which should be considered as innovative in format while keeping many principles of the model intact. It is the purpose of this paper to summarize areas in which we believe the Flexner Model is weak and to indicate our approaches to change.

Weaknesses of the Flexner Model

The Flexner Model has strengthened the university health center to an unprecedented degree. In doing so it has also engendered a caste system in medicine which ultimately has been a disservice to its graduates and more importantly to patient care. The model inherently produces a "town-gown split," and this has led to increasing estrangement between academicians and physicians who deliver patient care. The



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THOMAS E. GAMBLE, Assistant to the Dean of SBMS-U, received a B.A. from Northwestern University in Biology and Chemistry in June 1964 and the Masters of Education in Higher Education from the University of Illinois in June 1970. He is currently a candidate for the Ph.D. in Higher Education Administration at the University of Illinois.



JOHN D. ANDERSON, Ph.D., is Professor of Physiology and Associate Dean of SBMS-U. He has been in charge of the Department of Physiology and Bio-physics—upper division beginning graduate courses in cellular and experimental animal physiology. Dr. Anderson is a charter member of the Association for Multidiscipline Education.

"LMD" is often a hostile academic term describing the backward physician whom the clinical scientist fancies as one to be pitied and occasionally tolerated. Trainees of the academic center who decide to enter private practice away from the center often do so with a guilty conscience, feeling that they have done so for base and materialistic reasons.

To counter this, there has been an increasing emphasis on specialization which provides an academically acceptable alternative to family practice. But specialization, for all its virtues and virtuosos, may represent the greatest threat to the fundamental role of the physician as the leader of the health care team. The ultimate specialist is a technician, and the supply of specialists may never meet demand.[4] Even specialized knowledge is rapidly and creatively being supplanted by the computer.

We have also noted increasing dissatisfaction with the process of continuing education. There is widespread concern that the detail men of the pharmaceutical industry provide most of the post-graduate education that is delivered to the practicing community. Continuing education programs reach only a modest fraction of the physician pool with an effectiveness that is difficult to evaluate,[5] and often challenged.[6] We believe that failure in continuing education has much to do with a system that rejects the dignity of the practitioner.

A third major area of difficulty with the model is that it has been extraordinarily expensive. We are now entering an era where the investment in educational institutions is tapering off. Medical school developments which in the past have required capital investments of over $1,000,000 per class place are being reduced to fractions of that figure. The model frequently ignored practicing physicians as a major resource for medical education, relying on full-time equivalents in their place. Now the numbers of basic scientists and clinical scientists who could devote a large majority of their time to research are being trimmed; and those remaining are required to be more productive in the teaching sphere.[7]

A fourth challenge that faces traditional medical education is the Procrustean treatment of medical training in the bed of time. Four years have achieved a magical significance as the proper period of time for training physicians. This figure is now receiving widespread challenge as more curriculum committees and legislators understand that the product desired is a qualified physician, not an individual with a punched four-year time card in his possession.

Finally, in discussing problems of the Flexner Model, the subject of relevance is raised time and again.[3] In reality, practically all of every basic science curriculum can be relevant to the practice of medicine, but the model has failed to demonstrate it so. Material is often presented more out of context for the medical student than truly nonrelevant. The isolated fact that certain molds inhibited the growth of bacteria on culture plates remained unheralded and "nonrelevant" for a decade until it was appreciated that penicillin was effective against pneumococcus *in vivo*.

We have attempted to provide solutions which bear constructively on these problems and on the sound system of education which we acknowledge.

Basic Assumptions in the Approach to Innovation

We have developed a curriculum in the basic medical sciences on the following assumptions:

(1) That all students admitted to the medical program have the ability to achieve the M.D. degree. Failure to complete the program will be determined by the student himself.

(2) That it is possible to define what the student should *learn*. This can be considered a type of core curriculum approach. We emphasize learning rather than teaching, because the former places more of the burden of progress on the student, while the latter can be discharged solely (and sometimes indifferently) by faculty.

(3) That student progress through a curriculum should be in accordance with his ability to master the curriculum goals. Time is less important than understanding and *the student becomes the rate limiting factor in his own education.*

(4) That basic medical science learning can be approached from multiple entry points and can be adapted to individual learning styles to take advantage of the varieties of motivations present among different students.

(5) That the fundamental goal of a medical school is to train the individual as a physician first, not a specialist. A physician is an individual who can deal with any medical problem in a logical manner either by direct care or proper referral.

(6) That basic medical science which is pertinent to the medical education of the student is pertinent to the physician in

practice.

(7) That practicing physicians represent a largely untapped pool of enthusiasm and talent for teaching.

(8) That medical education and continuing education may be carried on simultaneously so that the student, the practicing physician, and the community are best served.

(9) That relevance in medical education is more a problem of curriculum presentation to students and practicing physicians than it is of properly chosen subject matter in the basic medical sciences.

(10) That medical basic sciences should be taught in an atmosphere of medical care with the student learning in a doctor mode rather than as a graduate student.

The Program of the School of Basic Medical Sciences-Urbana

Our basic science curriculum has been organized to provide the beginning medical student with skills which will allow him to enter a clinical training program for the M.D. degree. In each of the several disciplines he must: (1) learn the discipline language; (2) be able to interpret data related to the discipline and have a familiarity with current literature; (3) be able to interpret signs and symptoms of diseases in terms of basic science principles; (4) achieve minimum passing levels on internal comprehensive examinations and external examinations such as those given by the National Board of Medical Examiners; and (5) achieve self-instructional skills that will allow him to keep up-to-date with passing time.

Learning is accomplished in an independent study, problem-oriented mode. The student acts as a physician in defining and understanding the basic medical science of the problem. A specific patient problem selected by the student, is the entry point into interdisciplinary principles of basic science. For example, peptic ulcer raises problems in the anatomy of the upper GI tract, its histology and pathology, the physiology of digestion, the biochemistry of digestive enzyme action, the pharmacology of anticholinergic drugs and their relationship to the autonomic nervous system, and the behavioral problems relating to ulcer. A schematic illustration of ulcer as a clinical problem in the medical basic sciences can be illustrated with the total content of each discipline. For each discipline there is also an outline of references and other software related to the discipline. In dealing with the problem of ulcer the student approaches many areas across discipline lines. Each has specific relevance to the clinical problem at hand, but also may have relevance to other problems. The immunological reactions of blood grouping are approached when studying transfusion for the bleeding ulcer, but also may be studied in cases of open heart surgery, the loss of blood through trauma, or through a case of acquired hemolytic anemia.

The Role of Clinical Faculty (Practicing Physicians)

The student is assisted in the learning process by faculty. Primary responsibility of faculty is to facilitate learning by the student and to evaluate his progress.

Each student is assigned one advisor, a non-salaried physician in full-time private practice, who will devote 4 hours per week to teaching. He is equipped with all student texts and evaluation procedures for each section of the curriculum. More importantly, the advisor is equipped with his own unique experience, and has accepted the responsibility of guiding his student through the basic medical science curriculum.

The one-to-one relationship between student and advisor is the *key* to the program. It is a relationship in which *both* are learning. No pretense is made that the advisor "teaches" biochemistry. The advisor, however, aided by the evaluation system, can ascertain whether the student has "learned" biochemistry. Learning by the advisor is a secondary, but no less important gain. The program is an on-going continuing education for him without significantly interfering with the service of his practice.

Finally, the advisor holds a share of real academic responsibility. He is an integral member of the teaching faculty. Also, he is not the preceptor of Pre-Flexnerian days, since there are defined learning goals for each clinical problem. Instead, he functions as a dedicated physician, with a deep sense of mission and obligation in medical education. It is this fact which has made our program possible.

Behind the advisor is a second echelon of non-salaried physicians, the evaluators. The task of the evaluator is to provide another view of student progress. Evaluators see four students weekly for approximately one hour. Equipped with texts and evaluation material their role is to provide a follow-through to student learning. When the advisor is satisfied that his student has completed the curriculum for one problem,

an appointment is made with the evaluator for a second review and opinion. The evaluator probes for weaknesses and adds new clinical insights for the student. The evaluator, in consultation with the advisor, makes the final decision as to whether or not the student may progress to the next problem.

The Role of Full-Time Faculty

The combination of independent study, and advisor-evaluator input into basic medical science education has changed the role of the full-time campus faculty. They are no longer confined with the routine chores of lectures and laboratories. Instead, they devote themselves to continued updating of curriculum and to seminar teaching based upon problems not readily solved by students and their advisors. Each campus faculty member, a Ph.D. in one of the basic science disciplines, also serves as a personal advisor to three or four students. This allows him an opportunity for broad contact with other disciplines and the clinic.

Just as the program is designed to broaden the physician in his outlook toward basic medical sciences, this area of faculty involvement allows for the Ph.D. to become familiar and sympathetic with the problems facing physicians, and for reversing the trend toward continued isolation of the basic medical scientists from the practice of medicine.

Details of Curriculum Design

In our pilot programs with 16 students in 1971-1972 and 32 in 1972-73, we have elected to cover the core material by exposure of the student to 12 common clinical problems: cellulitis, laceration, coronary heart disease, emphysema, peptic ulcer, cerebral vascular disease, pregnancy, diabetes mellitus, drug reaction, dermatitis, cancer, and upper respiratory infection. The first two of these, cellulitis and laceration, are studied in unison in a four-week introductory period. Thereafter the students work independently with their advisors on the remaining ten problems. Ultimately, we hope to offer the student a choice of as many as 60 different problems from which a suitable variety of 10 to 15 will be necessary to cover the core material.

The following basic medical sciences have been detailed in the first year curriculum: anatomy-gross, microscopic, and topical; biochemistry; microbiology; immunology; physiology; pharmacology; pathology-general, gross and microscopic; neuroanatomy and neurophysiology; genetics; behavioral sciences; and the art of history and physical diagnosis. Each was developed by a team of 3 persons: 1 basic scientist who served as a content expert, and 2 practicing physicians who served to relate content to clinical problems. Each curriculum development team maintained as a central principle the definition of elements and skills of the discipline which were necessary for the practice of scientific medicine. This has not resulted in massive deletions of content material, but has produced a detailed curriculum in which each unit of learning is consciously related to the clinical problem being studied.

In breaking the lock-step approach to teaching the basic medical sciences, we are aware that the proposed 40 weeks may be too long for some and too short for others. In essence, we are encompassing the major bulk of what previously was learned in the first two years of medical school. In our favor is the fact that premedical students are better prepared for medical education than ever before. Subjects such as biochemistry, physiology, genetics, etc., are commonplace in undergraduate studies. For those who do not complete the program in the allotted period of time, the clinical schools of the University of Illinois are developing flexible curricula to allow entry of students whenever they are qualified.

It is also evident that problem orientation demands a restructuring of the sequential learning pattern that is classical in medical teaching. Pathology and physical diagnosis, which are ordinarily subjects for the second year of medical school, come to the forefront. The medical student deals first with pathology and gleans from this an understanding of the normal. This simple turnabout provides a relevance that was always present but never exploited by classical medical education. Physical diagnosis at an early stage takes advantage of the enormous motivation of beginning medical students and for this reason we have dropped the term medical student in favor of "Beginning Doctor" (BD). This has met with acceptance by patient, physician and, of course, the beginning doctor himself.

We accept the fact that this is a preliminary report of a highly experimental approach, but we are encouraged with progress to date. The first group of 16 completed the nine-month program in June, 1972. All passed the Freshman Comprehensive Examination given to 251 freshman students at the University of Illinois College of Medicine, and 15 of 16 passed Part I of

(Continued on page 49)

medical progress

By Harvey Kravitz, M.D./Morton Grove

Lead Poisoning

THE RECENT DISCOVERY of high levels of lead in the blood of children living in a number of towns and cities of Illinois has highlighted the need for all physicians to be on the alert for cases of lead poisoning.

Early recognition of lead poisoning by the physician is only part of the solution of this problem. It is the responsibility and the duty of local and state officials to take every necessary measure to prevent lead from poisoning the environment of children and adults.

This responsibility has been met by the Chicago Board of Health, which in 1966 instituted the first mass screening for blood lead of children living in high risk neighborhoods. Since the inception of the program over 200,000 children have had blood lead determinations.[1,2] Concurrently, a special lead clinic was established in 1966 under the direction of Henrietta K. Sachs, M.D., for diagnosis and treatment of patients suspected of having lead poisoning.

The Illinois Department of Public Health has recently established the first state-wide Lead Poisoning Detection Program under the direction of Philip R. Fine, Ph.D. Over 6,000 blood lead levels have been performed in 14 towns and cities throughout the State. Early reports indicate that blood lead levels of 60 micrograms or higher were found in a significant percent of children tested in Aurora, Springfield, Peoria, East St. Louis and Decatur.

What can be done to increase and heighten the physician's index of suspicion in regard to the diagnosis of cases of lead poisoning?

Physician's Suspicion of Poisoning

A. The physician in private practice should be on the alert for potential cases of lead poisoning among children between one and five years of age, who live in pre-1940 housing. He should look for the following manifestations:

1. *Pica*
2. *Anorexia*
3. *Irritability*
4. *Apathy*
5. *Clumsy or ataxic gait*
6. *Pallor due to associated anemia*
7. *Vague abdominal pain*
8. *Constipation*
9. *Developmental delay, especially speech*
10. *Unexplained episodes of vomiting*
11. *Weight loss*
12. *Headaches*
13. *Night crying*
14. *Fatigue*

If the above symptoms are present the physician could consider the possibility of lead poisoning and hospitalize the child. He should also report the patient to the local health department as a suspect case of lead poisoning.

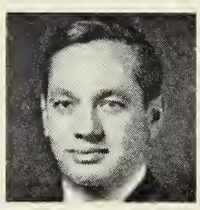
B. Suspicion of the physician in the emergency room should be aroused by a history of the preceding symptoms, plus the following:

1. *Forceful vomiting*
2. *Convulsions*
3. *Coma*

The emergency room physician should order the following tests:

1. X-ray flat plate of the abdomen to determine whether radiopaque material is present in the gastrointestinal tract. This is a valuable tool and is positive in 50% of symptomatic cases of lead poisoning.

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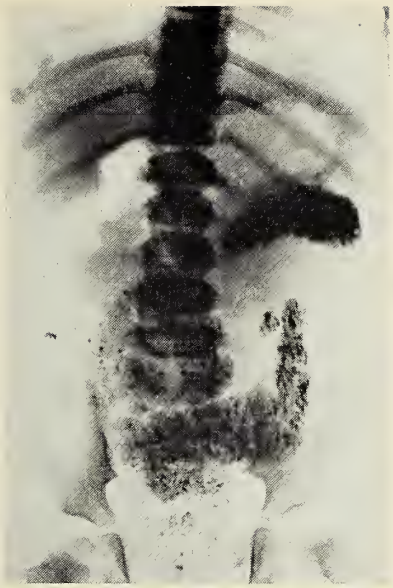


Figure I Single supine view of the infant's abdomen reveals radiopaque metalic material within the gastrointestinal tract.



Figure II A The views of the knee and wrist reveal heavy transverse lines in the ends of the shafts of the long bones. Some of the lines are in the proximal metaphysis indicating previous heavy metal ingestion.

2. X-ray of wrists and knees. Look for lead lines at the metaphyses. These are not always present in children under two years.

3. A urine sample should be collected immediately for a coproporphyrin test.[3] It can be done in the emergency room.

a. 5 ml of urine is acidfied with two to three drops of glacial acetic acid to give a Ph of 4 (checked with Hydrion Ph test paper.).

b. The specimen is extracted with 5 ml. of ether.

c. The ether extract is then removed and 5 ml. of 1.5 normal hydrochloric acid are added and carefully shaken under pressure by covering the top of the tube with the thumb.

d. A reddish orange fluorescence should be looked for in the lower hydrochloric acid layer by means of a Wood's lamp. A negative test does not rule out lead poisoning.

4. An immediate urinalysis is performed. Glycosuria, proteinuria, casts, WBC, RBC, and hyperaminoaciduria are often found in severe lead poisoning.

5. A CBC and reticulocyte count should be done (microcytic hypochromic anemia with elevated reticulocyte counts often are present.)

6. Smears of basophilic stippling (if trained technician is available to stain the smear.)

7. 5cc of blood is drawn for a lead determination and placed in a 10cc lead-free B-D3200 XF313 heparinized Vacutainer tube. A sterile disposable lead-free needle and a plastic syringe should be used in all cases.

The specimen should be sent by car to the Lead Poisoning Division of the Chicago Board of Health. The blood should be delivered to the blood chemistry laboratories located in the lower level of the Civic Center, Room 75. Call Dr. Herbert Slutsky, director of the Lead Poisoning Division at 312-744-4353, Chicago, for information concerning suspected or proven cases of lead poisoning and to report such cases. On weekends, holidays, and evenings call 312-744-4340.

Physicians practicing outside of the Chicago area, who need blood lead tests, should contact Dr. Philip R. Fine at the Illinois Department of Public Health by calling 217-525-3301, Springfield, or call Miss Eleanor Berman at the Hektoen Institute, 627 S. Wood Street, Chicago, 312-633-7191.

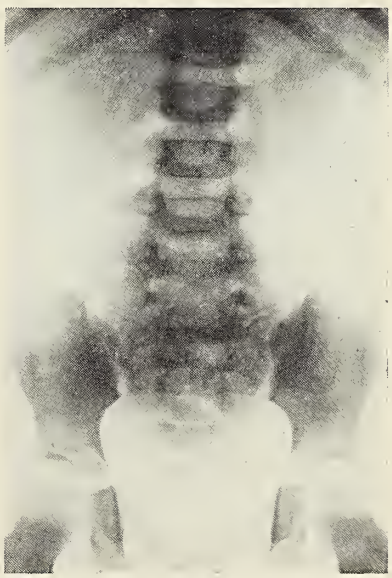


Figure II B This supine film of the abdomen reveals a rare finding of dense bands in the iliac bones from lead ingestion.

C. What can the house officer do in the hospital once the patient has been admitted?

Any patient with a blood lead of 60 micrograms or higher, whether asymptomatic or symptomatic, should be hospitalized for treatment or referred to the Lead Clinic if living in Chicago. This is the policy in the city of Chicago.[1,2]

The U.S. Public Health Service recommends that treatment begin if the blood lead level is 80 micrograms or over.[4]

As stated previously, the finding of radiopaque material in the gastrointestinal tract on X-ray, lead lines and a strongly positive spot test for coproporphyrin in the urine are clear and practical indications for starting therapy in patients with blood lead levels of between 50 to 79 micrograms per 100cc of whole blood.

Any patient who has the above positive criteria and is asymptomatic is considered a case of lead poisoning and must be treated as follows:

1. Start EDTA edathamil calcium disodium 50 mg per kilogram per day intra-muscularly in divided doses every 8-12 hours for five days. (Procaine is added to the solutions to decrease the pain.)

2. If radiopaque material is noted in the gastrointestinal tract after a flat plate of the abdomen, an enema should be administered immediately.

3. If the blood lead remains elevated after the first course of EDTA, a second course of therapy with EDTA is started two weeks after the completion of the first course.

4. Treatment of asymptomatic cases with lead levels of between 50-59 microgram with oral D-penicillamine 20-25 mg/kg. for one to three months is recommended. D-penicillamine is also indicated for persistently elevated blood lead evels after two courses of EDTA. This therapy is continued until the blood lead level is below 50 micrograms.

Lead Encephalopathy

What should the physician do to establish the diagnosis of lead encephalopathy?

Suspicion should be aroused by the signs of lead encephalopathy as previously listed (see Section B).

In the physical examination the physician should check for:

1. *Papilledema*
2. *Retinal hemorrhages*
3. *Widened sutures in infants*
4. *Signs of dehydration*
5. *Paresis or weakness of the dorsiflexors of the feet and wrists.*

The physician should order the following:

1. Blood electrolytes and hematocrit to determine the degree of dehydration.

2. A ECG since arrhythmias and conduction disturbances occur in cases of lead encephalopathy.

3. A spinal tap should be avoided if possible unless it is needed to rule out encephalitis or meningitis. Then only a few drops should be obtained to prevent herniation of the cerebellum.

4. All diagnostic tests done by the emergency room physician should be made available to the physician before treatment is instituted (see Section B).

Treatment of cases of lead encephalopathy and patient with blood lead levels over 100 micrograms of lead per 100 grams of whole blood is as follows:

1. Immediate and permanent separation of the child from the source of lead. The child is treated in the hospital until a lead free home can be found.

2. Treat all symptomatic children immediately as potential cases of encephalopathy. Do not wait for blood and urine lead reports if signs of encephalopathy are present.

3. Start intravenous 10% dextrose in water; 10-15cc per kilogram is given to establish a urine flow. If this fails start 1-2 gm. per kilogram of mannitol intravenously in a 20% solution at a rate of 1 ml per minute to carefully replace only the deficits of electrolyte. Do not overhydrate the patient. Keep the daily urine output between 350-500cc per square meter per 24-hours by giving between 60-80cc of intravenous fluid per day and adding fluids as needed.

4. Convulsions and muscle twitching are treated initially with intramuscular paraldehyde 0.15 ml. per kilogram. Dilantin and phenobarbital are given in the recovery period.

5. Reduction in the intracranial pressure can be aided by hypothermia. Maintaining the body temperature at 90-92° has been helpful when mannitol is not effective.

6. BAL and EDTA should be started immediately. BAL is given intramuscularly in a dose of 4 mg per kilogram.

The combination of BAL and EDTA is given as follows:

a. BAL is given as a fluid dose alone.

b. Four hours later and every four hours

thereafter, BAL and EDTA (12.5mg per kilogram) are injected simultaneously in separate deep intramuscular sites for five consecutive days.

7. Oxygen should be given if respiratory depression is noted.

Further hospital care and follow-up should include:

1. Repeat blood and urinary lead determination to see if chelation therapy has been successful.

2. Base line psychometric testing should be done during the hospitalization to assess the child's development.

3. Discharge and follow-up of each patient at monthly intervals with blood and urinary lead levels. The follow-up should continue until the age of six years.

4. Intercurrent infections and fevers may bring on symptoms.

5. Follow-up psychometric testing to determine neurologic damage resulting from lead poisoning.

6. A social service investigation of the child-parent relationship and living conditions of the family should be made before the child is released to the home.

7. The child should be enrolled in a Head Start Program or a pre-school or day-care facility to reduce the psychologic need for pica and provide proper social stimulus for learning.

8. The home should be thoroughly inspected by competent building inspectors. Lead paint should be removed from the walls or wood paneling should be used to cover the wall before a child is returned to his home.[5,6]

Conclusion

- Lead poisoning is a wide-spread disease.
- Mass screening of the population of the state should be continued.
- Doctors must develop a high index of suspicion concerning lead poisoning if cases are to be diagnosed early.
- Lead poisoning cases and suspect lead poisoning cases must be reported to each local board of health.
- Rapid blood lead determinations must be made available to all physicians in Illinois.
- Each hospital in areas of high risk should have a lead poisoning diagnostic kit in the emergency room. The kit should contain:
 1. Sterile plastic lead-free syringes and lead-free disposable needles.
 2. B-D heparinized 10cc lead-free Vacutainer tubes (L3200 XF313).
 3. Reagents to do a urine coproporphyrin including glacial acetic acid, ether, Ph test paper and 1.5 N hydrochloric acid.
 4. A manual for specific treatment of symptomatic cases of lead poisoning.
- Strict enforcement of building code violations regarding lead paint inside old houses must be carried out to make any lead program effective. ◄

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Crippled Children Clinics Slated For February

(Continued from page 10)

February 23 Evanston—St. Francis Hospital
February 27 Peoria—St. Francis Children's Hospital
February 27 Danville—Lake View Hospital
February 28 Aurora—St. Joseph Mercy Hospital
February 28 Springfield Pediatric Neurological-Diocesan Center

The Division of Services for Crippled Children is the offical state agency established to provide medical, surgical, corrective, and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling.

In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases the work of the Division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on in behalf of crippled children. ◄

Nutritional Labeling

By Elaine Maesson Wedral, Ph.D., Libby, McNeill & Libby/Chicago; and
Robert W. Harkins, Ph.D., Grocery Manufacturers of America, Inc./Washington, D.C.

This is one of a series of papers presented at the Fourth Symposium on Nutrition and Food Technology, March 29, 1972, Lake Shore Club, Chicago. The symposium was co-sponsored by the Illinois State Medical Society, the Chicago Nutrition Association, and the Institute of Food Technologists-Chicago Chapter.

Nutritional labeling is likely to stimulate more interest and diverse opinions than any other proposal in recent times. On the eve of publication of the Food and Drug Administration (FDA) proposal on nutrition labeling, it is appropriate that we gathered for this symposium on nutrition and nutritional education. The FDA proposal[1] will be published tomorrow (March 30, 1972) in the Federal Register and a 90-day comment period provided for interested parties. Industry, consumer and government groups have each formulated their own views in anticipation of this publication. It is the FDA's task to formulate an initial proposal, invite comments, and then reconcile the comments into a final proposal which will regulate nutrition labeling practices in this country. It is my assignment to point out some of industry's concerns and views on nutritional labeling.

At the outset, it is important that everyone understand that the American food industry supports and will continue to support efforts to upgrade the American diet. Providing consumers with information about the nutritional composition of foods is an effort that can result in improved diet selection, and hence, we support nutrition labeling. There will, no doubt, be honest arguments about *how* nutritional labeling should be designed; there will not be arguments about *whether* nutritional labeling should be permitted. The ability of the American food industry to implement labeling will depend to a large extent on the regulatory requirements set forth by the FDA. The more stringent the requirements, the greater must be the investments in equipment and manpower to guarantee the label claims.



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Constituents In Labeling

Nutritional labeling by definition means the inclusion on the consumer package of information about the nutritional composition of the food. It could be simple, perhaps no more than a declaration of the calorie content; or more complex, including statements of the protein, fat, and carbohydrate contents; and even more complete, but not necessarily more understandable with the addition of statements about the vitamin and mineral properties of the food. Heretofore, the only permissible way to declare vitamins and minerals was as a percentage of the minimum daily requirements.[2] As an aside, most consumers have not understood that FDA has effectively prohibited manufacturers from describing the nutritional composition of their foods, since the act of labeling has been consid-



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ered as transforming food into one for special dietary use.

Minimum daily requirements (MDR), established by FDA in 1951,[3] were chosen such that amounts less than these would produce demonstrable deficiency signs. They are minimums, as contrasted to optimal intakes which are below what an individual should not go.

In contrast to the MDRs, the nutrition community has by and large endorsed and adopted the Recommended Dietary Allowances (RDA) as established by the Food and Nutrition Board of the National Research Council. The RDAs were most recently revised in 1968[4] and have been updated about every five years since first published in 1940. The RDAs were designed "to be adequate for the maintenance of good nutrition in the population of the United States." Hence, they can serve as an optimal goal, in contrast to the MDRs which establish minimum intakes.

Table 1 shows the contrast between the MDRs and the RDAs. As you can see, the RDA levels are 25% to 100% higher than the MDRs. These higher values for the RDAs were purposely selected by the Food and Nutrition Board; in their words:

> "The allowances are intended to serve as goals for planning food supplies and as guides for the interpretation of food consumption records of groups of people. If these RDAs are used as reference standards for interpreting records of food consumption, it should not be assumed that malnutrition will occur whenever the recommendations are not completely met."

The following interpretation is also given by the Board:

> "Except for calories, the allowances give a margin sufficiently above average physiological requirements to cover variations among practically all individuals in the general population."

The pending FDA proposal will utilize the RDA rather than the MDR as the reference for nutrition labeling. We support this change from MDR to RDA. However, one note of caution: If a consumer does not receive 100% of the RDA each day, it does not mean that nutritional peril is at hand. Because of the construction of the RDAs, there is latitude. This is just one of the difficult educational concepts that will need to be explained and reexplained for consumers in the coming months and years.

Since the real objective of nutrient labeling is to provide sound, useful information on the composition of foods, we must continually ask—how best can this be accomplished. Fortunately, the FDA proposal was preceded by a variety of research projects sponsored by both private and government agencies. These studies have gone a long way in structuring the FDA proposal. We are encouraged by this development, that is, the use of market research to investigate the marketplace before the construction of government policy. This is a healthy development, one that we encourage and hope will be used by other regulatory agencies in their policy planning. Certainly, it is the proven pathway in our profit-oriented corporations and one that does have the potential to improve the public policy aspects of government.

TABLE 1
Comparison Between Adult Recommended Dietary Allowance (RDA) and Minimum Daily Requirement (MDR)

Nutrient	RDA	MDR
Vitamin A (I.U.)	5000	4000
Vitamin C (mg)	60	30
Niacin (mg equiv.)	20	10
Riboflavin (mg)	1.7	1.2
Thiamine (mg)	1.5	1.0
Calcium (g)	1.0	0.75
Phosphorous (g)	1.0	0.75
Iodine (mg)	0.15	0.10
Iron (mg)	18	10

RDA Values in Nutrient Labeling Proposal
MDR Values—Food & Drug Administration—1951

Consumer Research Institute Study

The most important of the market research studies which preceded the FDA proposal was conducted by the Consumer Research Institute (CRI).[5] In the first phase of the CRI study, the food purchase behavior of 950 educated, middle-class households in Connecticut and Georgia was monitored. These families did most of their grocery shopping at home using a catalog of food items. Food orders were placed by telephone and delivered to the families the next day.

Various formats for nutrient labeling were examined, and the following results were found:

1. Nutrient information was used by consumers observed in this study.
2. In situations where a product or brand has a real nutritional advantage over its competitors, there was a major change in share of market.
3. The consumers' attitude toward nutrition were found to be rather high before the introduction of nutrient labeling. The changes in attitudes were positive, but small.

4. Three different modes of communicating the RDA concept (numerical, such as 10%; verbal, such as poor, good or excellent; and pictorial, such as smiling faces) were used equally well. It would not appear that any one mode has a major advantage over the others among the educated and affluent in our society.

A second phase of the CRI study utilized questionnaires sent to a representative sample of 2,000 homemakers and 2,000 consumers representing low-income groups; in addition, 600 consumers representing the "under-educated poor" in inner cities were interviewed face to face. (For the purpose of the study, "under-educated poor" was defined as having less than a high school education and having an annual family income under $5,000.) The purpose of the study was to determine which mode of communicating nutrition information would be best understood and most useful to consumers (numerical, verbal, or pictorial representations), as well as to determine whether or not all key nutrients (five vitamins and two minerals) or only those present in given foods should be listed.

Results showed that 71% of lower income consumers correctly chose the most nutritious product *using* the numerical or pictorial systems; 66% could select correctly when adjectives were used. When asked which labeling method was preferred, the low-income, under-educated consumers indicated that numerical percentages were preferred by 49%, adjectives by 33%, and pictorial units by 18%.

Yankelovich Investigation

Another study by the Daniel Yankelovich Research Organization investigated the impact of full disclosure nutritional labeling on consumer purchases. The proposition studied was: Suppose that all packaged food products carried labels that prominently disclosed full information about ingredients, including nutritional value—proteins, carbohydrates, fats, minerals, water content, and calorie content. What effect would this have on consumer purchases? Would consumers buy the product that offered the most nutritive value for their money? How would "national" brands fare against private labels selling for considerably less?

This study was conducted at Yankelovich's laboratory—a simulated supermarket located in Upper Montclair, New Jersey. Two cells of 200 housewives each were employed and eight categories of food were tested. In one cell, the control, no packages were labeled for special nutrition disclosure. In the second cell, nutrition labels were alternated from the leading brand in each category to the secondary brand or private label in order to study possible shifts. The study revealed the following:

1. Consumers are concerned about nutritive value, and it is significant in their purchasing. However, it is not as major a factor in food purchasing decisions as is price or quality image.
2. The dominate brand or market leader held its share of purchases even in the face of full disclosure labeling of a secondary brand. It seems housewives have an abiding faith that major brands are good products, high in nutritive content.
3. Store brands or private label brands do not hold their share of the market in the face of full disclosure labeling on competitive products. It appears that nutrient labeling generates attention and this attention may depress the economic motives which act as a primary reason for private label brand-buying.
4. Full disclosure labeling has its major effect upon secondary brands. The second or third brand in the category, as long as it is not a private label brand, shows the greatest increase in share under nutritional labeling circumstances.

Food Chains Participation

Five food chains have also worked with FDA in studying nutrient labeling: Giant Food, Baltimore and Washington; Jewel Food Stores, Chicago; The Kroger Company, Cincinnati; First National Stores, Boston; and the Berkeley Co-op, California. The tests varied in their approach, yet the findings were quite similar. Each chain felt that nutrient labeling promoted nutrition awareness. One report from Jewel Foods stated:

> Our current prognosis is that the average consumer will perhaps derive the greatest benefit from the nutritional awareness aspect of our labeling program, as opposed to the benefits of knowing the specific information on each label.

All these studies have their merits and limitations; however, they also do indicate that consumers want nutrient labeling and that this nutrient labeling promotes nutrition awareness. But labeling fulfills only a part of society's need. We cannot expect labeling to

replace the need for nutrition education. It will be up to all parts of our society—industrial, educational and regulatory agencies—to fulfill the second and more important need, education.

Over the years, nutrition labeling has been available on two types of consumer products—foods for special dietary uses, such as infant foods, hypoallergenic, low calorie products, and others; and pet foods. When a product is designed to be the sole article of the diet, as it would be for an infant formula, specific labeling has been required by the FDA. These requirements have been based on the MDR concept.

Similarly, pet foods for years have included information about the nutritional composition of the foods. This type of informative labeling was developed as a guide to pet owners and because the pet food would, in many cases, serve as the sole article of the diet. Some consumers, seeing informative labels on pet foods and not on conventional foods, have concluded that pets are better fed than people. It is relatively easy to simulate the nutritional status when the food intake is homogeneous and unchanging. However, to project the nutritional status when one is selecting from the thousands of food products available in a modern supermarket presents a much more formidable task. That is the task of the consumer. It is the responsibility of the food industry and government to assist consumers in eating well. We will need to avoid the trap where consumers may assume that they are better fed simply because labeling is present on some consumer products. Assuring the nutritional well-being of free-living individuals choosing from a variety of foods does and will continue to require motivation on the part of consumers.

Problems of Nutrient Labeling

We have discussed the need and benefits of nutritional labeling, but there is also another part—the problems. The Food and Drug Administration has stated:

> "In developing a nutrition labeling system it is, therefore, important that the manufacturer be permitted a sufficient tolerance so that he may provide useful nutrition information on the label without incurring excess cost for quality control which may result in a significant price increase to the consumer. However, consumers will expect that the nutrition label will honestly represent the product."

As sensible a statement as this is, it is not adequately reflected in the proposed regulation which states that 80% of the packages covered by the label must meet or exceed the claimed nutrient level, and that no sample of the product is to have a nutrient content less than 80% of the nutrient claim. This very restrictive provision, if implemented, would force the food processor to expend large sums of money analyzing the finished product and then to markedly *understate* the nutritional value of the food. This is an important consideration which deserves explanation, as illustrated in Table 2.

TABLE 2
Ascorbic Acid in Tomato Juice
6 Oz. Serving

Range	**1.8—45.5 mg**
Average	**24.1 (±8.9) mg**
RDA	**60 mg**
Percent RDA	
In Average Serving	**40%**
Required Label Statement	
To be exceeded by 80% of samples	**30%**
Determined by minimum value	**0%**

The National Canners Association Laboratories have been studying the nutrient content of selected canned foods. The data in the table is based on 1969 pack results. It shows that the milligrams of vitamin C in a six ounce serving of tomato juice may vary from 1.8 to 45.5. An average serving provides 24.1 mg or 40% of the RDA. The figure in the parentheses (8.9) is the standard deviation of a single composite sample. These samples had been stored 8-12 months prior to analyses.

A product furnishing 40% of the RDA makes a significant contribution to the nutritional well-being of the consumer. In light of the 80-80 stipulation, let's see what the label declaration would be. In order to guarantee that 80% of the packages exceed the declared value (using appropriate statistics), the label declaration can only be 30% of the RDA. The second requirement, that no package shall contain less than 80% of the declared value, reduces the declarable level on the label to 0!

You may ask why variations from 1.8 to 45.5 mg occur. Uncontrollable variations are normal and natural. For example, tomatoes grown in shade or during a season of less sunshine are lower in vitamin C than those exposed to full sunlight during the full growing period. We have also found differences in the vitamin A content of tomato juice produced on the West Coast versus the Midwest.

Perplex Questions For Industry

One must ask the question: What is the real

purpose of nutritional labeling and what level of nutritional accuracy does the consumer need? Would stating the average amount of the nutrient the consumer receives over a reasonable period of time be considered "accurate" labeling? Or, as suggested by the proposal, must the nutrient content be grossly understated (i.e., half the vitamin C in tomato juice) so that most packages exceed the declaration?

What will happen to seasonal items? Labels for seasonal products must be manufactured far ahead of the growing season; product variations which are likely to occur due to variety, growing season, growing area, and climatic conditions cannot be fully anticipated.

Another problem is the natural degradation of nutrients upon storage. Should the nutrient label declaration reflect the vitamin content of the package at time of production? Six months later? One year later? Or three years later? Will products have to be recalled every year or two for re-analysis and re-labeling? This seems completely impractical.

Cost of Nutrient Labeling

Still another problem which faces all of us as consumers is the cost of a program of this nature. Contrary to the implications of many political and consumer spokesmen, food companies are not "getting fat." When you compare the food industry with other industries, the food industry consistently has one of the smallest percentages of profit.

Table 3 was taken from *The Wall Street Journal* (March 28, 1972) and shows the increase in gross profit of various industrial groups in the first quarter of 1972 compared to the first quarter of 1971. As you can see, the food industry profits have not increased but *decreased.* Food commodity–oriented companies have the same problems consumers have–rising costs of supplies, rising labor costs, and rising transportation costs.

Food companies cannot realistically spend millions of dollars on nutrient labeling without the consumer bearing much of the burden. The industry believes that the nutrition labeling program selected should give the consumer the most useful information for the least amount of money. Rigid regulations, like those proposed, will involve extremely expensive control programs. Unfortunately, requiring a high degree of precision for the label claims adds little to the consumer's ability to choose a nutritionally adequate diet but adds substantially to the cost of food production.

TABLE 3
1971-72 Profit Comparison

	1st Quarter
Food Products	**— 2.7%**
Total Industries	**+11.8%**

Nutritional analyses are extremely expensive. The National Canners Association has quoted a price of $770 per single sample for nutritional analyses. If we forego evaluation of protein quality, the cost is reduced to $470 per sample. In order to establish any type of label claim on the basis of the 80-80 stipulation, companies will need to analyze at least 50 random samples. That means "one" product would cost approximately $23-$24,000 for analyses. This cost does not include label costs, monitoring costs, storage study testing, and many other necessary expenses. Nutritional labeling as being initially proposed will be expensive.

What about the small company? What effect will these costs have on its survival in the marketplace? Will small companies be able to afford adequate outside laboratory analyses to meet label regulations? We are hopeful that compromise will be achieved without compromising the value of nutrition labeling.

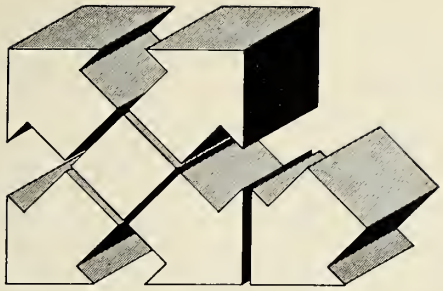
In its broadest aspect, nutritional labeling's primary value will be as an educational effort designed to provide sound information to consumers on the nutritive properties of food.

The White House Conference on Food, Nutrition and Health recommended that the FDA consider the development of a system for identifying the nutritional qualities of food: "Every manufacturer should be encouraged to provide truthful nutritional information to consumers about his products."

It is the responsibility of all of us to respond to the new FDA nutrition labeling proposal and work with FDA and all concerned parties to give consumers the best nutrition and the most useful labeling for the least amount of money. ◄

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trauma center

David R. Boyd, M.D.C.M., *Editor*

Resection of The Distal End of The Ulna

Case Report: 13-Year Post-Trauma Study

In children the fracture of the distal end of the forearm bones is, in the majority of cases, adequately treated by closed reduction and immobilization. However, in adults, the fracture of the distal end of radius end ulna with dorsal displacement of the distal fragments (Colles' fracture) is commonly inadequately treated by closed reduction.[4-6] The comminution of the distal end of the radius induces shortening of the radius and deformity of the wrist joint. Deformity is a radial deviation of the hand, prominent ulnar styloid process and loss or limitation in motion, especially in rotation.

Recommended treatment in the orthopedic literature is the resection of the distal end of the ulna[3,7,8] in order to allow rehabilitation from or prevention of a severe disability of the distal radio-ulnar articulation.

The following case report relates a post-trauma study of a patient who sustained a fractured distal forearm and was treated by secondary excision of the ulnar end. Delayed appearance of an osseous bridge between the distal ends of the bones produced a practically ankylosed wrist joint.

Case Report:

In 1957 a 19-year-old Negro male sustained an open fracture of the distal end of the radius and ulna with dorsal displacement. An early operation of wound excision and reduction of the fracture was performed without internal fixation. An external cast immobilization was applied. The cast was removed one month later; severe limitation of the wrist motion was noted and a painful, swollen joint found. In order to allow greater mobility, a second surgical procedure was performed three months later and the distal end of the ulna removed. No physical therapy was ordered and no follow-up study done. Previously the patient had been employed as a precision mechanic; he later became a driver of light trucks. During the next 13 years the patient received no additional treatment. During this period the patient experienced early fatigue and swelling of the wrist after manual work.

In 1970 the patient sustained multiple blunt injuries to the head and abdomen and was admitted to the Trauma Unit of Cook County Hospital. During routine examination, the wrist was found to be slightly swollen but without tenderness. Two old scars were noted on the dorsal and ulnar sides of the distal forearm. The range of motion in the wrist joint was: dorsal flexion—0.°, volar flexion—15.°, minimal ulnar and radial abduction. Neither passive nor active pronation or supination was noted. An X-ray examination disclosed a distal radio-ulnar osseous bridge formation. Slight osteoporosis of



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the carpal bones and a cystic formation in the pyramidal bone were noted as well as an old healed fracture of the second metacarpal shaft.

Discussion

Resection of the distal end of the ulna was first performed by Darrach in 1912.[2] Since then the technic has been used in wrist deformities in post-traumatic states and in degenerative changes as well as in congenital anomalies.

In 1949 the procedure was reintroduced in the orthopedic surgical armamentarium by Freese in cases of comminuted Colles' fracture. After a series of 61 operations it was concluded that "fewer malunited fractures of the lower end of the radius will be obtained if the lower one inch of the ulna is resected at the time of reduction of the radius."[4] The required immobilization time was 8 to 12 weeks in a high cast.

This procedure has proven successful and many positive reports can be found in the literature. It was recommended as an excellent orthopedic procedure in malunited or non-united distal radial fractures with radio-ulnar dislocation.[8]

The excision "should be done subperiosteally to encourage regeneration of the distal end of the ulna."[3] However, opinions concerning the needed immobilization time have changed in the last decade. Evidence in favor of earlier rehabilitation of motion with a shorter immobilization period has been presented.[3]

In 1969 a comprehensive study was conducted by Spira and Weigel in which superiosteal removal of the distal inch of the ulna was recommended as the treatment of choice. "[It] should be performed primarily together with the reposition of the collapsed radial end."[7] [The authors recommend surgery under local anesthesia with tourniquet anemia, a short cast immobilization for a period of 3 to 4 weeks and early intensive physical therapy.]

Although the reports mentioned above are encouraging, all had only a relatively short term followup, varying from a minimum of a few months to a maximum of two years.

The present case, inadvertently found, has a follow-up period of 13 years in a relatively young patient. The result of a practically ankylosed joint gives rise to several problems which must be solved by a comprehensive study on a long-term follow-up period. Resolution of the question of intra- or extra-periosteal resection of the ulna requires preoperative study and postoperative observation of the effects of immobilization and physical therapy. ◄

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Hepatitis Passed From Mother to Unborn Baby

You don't have to be a drug abuser shooting up with an infected needle or the hapless recipient of a contaminated blood transfusion to get serum hepatitis—all you have to do is be born to an infected mother.

According to *JAMA*:May 22, 1972, Serum hepatitis, can be transmitted to babies before birth through the placenta or during delivery.

It was commonly assumed that serum hepatitis could be contracted only through procedures which broke the skin such as transfusion, vaccination or drug abuse; it now appears that it can be transmitted through placenta, during delivery and possibly through very close personal contact, sexual contact or biting insects.

surgical grand rounds

Edited by John M. Beal, M.D.

Blood Flow Measurements in Surgery

Case Report:

Dr. Wikholm: A 63-year-old white male was brought to the Emergency Room of Northwestern Memorial Hospital in September, 1972, where he was found to have a ruptured abdominal aortic aneurysm. Operation was performed immediately and a bilateral aorto-femoral graft was accomplished.

The patient recovered well. However, after discharge from the hospital, he experienced numbness and tiredness of the thigh on standing and on walking. His rehabilitation was hampered by this symptom and he was unable to return to work. At no time was actual claudication present. The patient was readmitted for evaluation. He denied rest pain but reported that his right leg would "go to sleep" when he crossed his legs. He had smoked 30 cigarettes a day for 44 years except during the last two years when he had stopped smoking cigarettes, but continued pipe smoking.

At the time of the physical examination, he was found to be an obese male with normal vital signs. Significant physical findings were confined to his lower extremities. The skin of both lower extremities was cool however there was a good capillary filling present and trophic skin changes not noted. Popliteal, dorsalis pedis and posterior tibial pulses were absent on the right side. Laboratory studies included a normal blood count and urinalysis. Electrocardiograms showed a normal sinus rhythm with nonspecific ST changes. The blood cholesterol level was 297. The first definitive study was an arteriogram.



Figure 1

Dr. Abram Cannon: This is the retrograde femoral arteriogram and we can see the aorto-femoral grafts on either side are widely patent but as we look at the femoral artery (figure 1), on both sides there are marked atherosclerotic changes throughout the course of the superficial femoral artery. No distinct, total occlusion is seen. Films made over the lower extremities show a good runoff from the popliteal into the tibial arteries. Also, we have a special view taken to show the branches of the deep femoral artery.

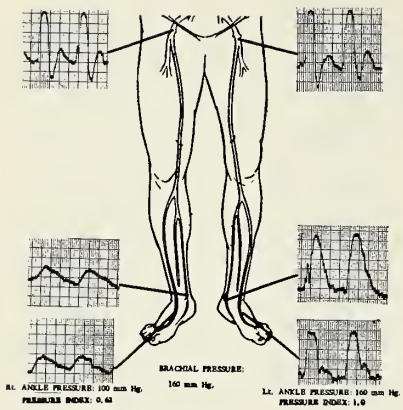


Figure 2

They are seen very nicely and again we see the atherosclerotic changes in the superficial artery.

Dr. Wikholm: So, essentially, we had a man with right sided calf and thigh pain of atypical description. There is an irregular superficial artery without total occlusion but with good run-off. This, then, was a good candidate for a peripheral bypass but the symptoms are obscure enough to cloud the diagnosis. Therefore, in order to reconfirm these findings, we took him to the Blood Flow Laboratory that has been set up by Dr. Yao. Figure 2 shows readings done with the ultrasound flowprobe. This is an instrument that is placed approximately at a 45° angle to the skin in the area immediately overlying an artery. A sound study is obtained which is heard and simultaneously recorded on standard electrocardiographic paper (figure 2). Notice in the femoral area how the pulse tracings show relatively normal flow. There is a sharp systolic rise, a quick fall and then a reversal of flow. This is characteristic of a normal arterial pattern. Notice on the normal left, the asymptomatic side which had normally palpable pulses, the tracing over the posterior tibial area is fairly good but not normal, and the dorsalis pedis pulse, which is a reflection of the anterior tibial, is noted with a reversal of flow which is almost normal.

After taking these tracings, a standard blood pressure cuff was applied to occlude the artery. Pressure at which the artery begins to flow is then compared to the brachial pressure. The patient had a brachial systolic pressure of 160 and on the left side the posterior tibial artery pressure was also 160. Therefore, the ratio of leg to arm pressure was 1.0 which is normal. On the right side, the flow pattern was abnormal. There was a slow systolic rise to a low amplitude and a slow fall without a reversal of flow as is seen in flow through collateral vessels. This is physiologic information which supplements the anatomic findings of the angiogram which, you recall, did not show a complete occlusion. The ankle pressure was also quite low. The pressure, instead of being 160 like the arm pressure; was 100 mm Hg and the ischemic index was 0.62. With this information obtained, the patient was taken to the operating room and during the procedure studies were done using the electromagnetic flow-probe. Dr. Yao will elaborate further on this now.

Dr. S. T. Yao: This patient's symptoms were quite atypical for claudication and he had a successfully functioning aorto-femoral graft. Therefore, as much information as possible was being obtained to evaluate his problem. Operative flow measurements were among the tests done.

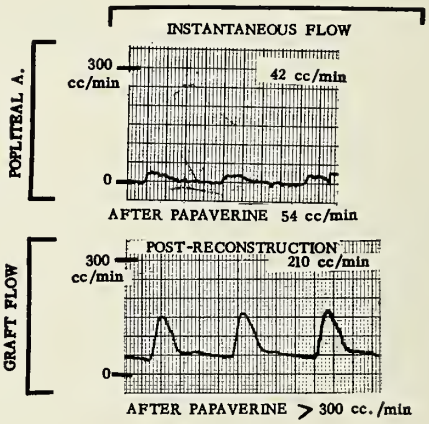


Figure 3

There are many types of flowmeters. We use the square-wave electromagnetic flowmeter because it is easy to use and it is the most accurate instrument available for measuring blood flow. The electromagnetic flowmeter allows volume flow to be recorded in ml/min, instantaneous pulsatile flow patterns to be obtained, and the mean flow to be ascertained. The flow probe is applied around an exposed artery or a graft. In the upper tracing (figure 3), flow measured in the popliteal artery in this patient during surgery is seen. This is, of course, distal to the stenosis. There is an abnormal flow pattern and the mean flow is only 42 cc/min. A smooth muscle vasodilator (Papaverine 15 mg) was given intra-arterially in order to evaluate the inflow capability of the artery and the vasomotor reactivity of the distal vascular bed. In this patient, blood flow increased only to 54 cc/min following administration of Papaverine. Such a minimal increase of flow is due to the proximal arterial

stenoses which were radiological patent. This confirmed the fact that the patient's symptoms were due to ischemia. After the insertion of the saphenous vein bypass graft, flow measured in the graft was a satisfactory 210 ml/min. An increase of flow to 300 ml/min was seen after the injection of Papaverine. This confirms the success of the operation and gives a good prognosis for the graft.

I would like to explain the principle of the electromagnetic flowmeter. Within the flow-probe, there are two electromagnets which generate a magnetic field at right angles to the direction of the blood flow. As the flowing blood cuts the magnetic lines of force, a pulsatile electrical force (voltage) is developed which is sensed by a pair of electrodes within the flow-probe. The flow voltage signal is directly proportional to blood flow and is carried through the sensor, amplified, integrated and displayed on the flowmeter where it can be recorded. Basic calculation of the flow is based on the law of electromagnetic induction discovered by Faraday (Faraday's Law).

For clinical use, pulsatile flow patterns recorded by the electromagnetic flowmeter give information concerning the ventricular function of the heart, wall properties of the arteries and the peripheral resistance of the distal vascular bed. In addition and most importantly, the volume flow can be determined accurately in ml/min and the direction of blood flow can be determined instantly.

The value of hemodynamic measurement during surgery is to confirm the restoration of blood flow and not just the pulse. It is possible for one to have blood pressure and pulse without blood flow.

Administration of Papaverine in surgery allows differentiation between vasoconstriction and technical error. This is especially true when a low flow value is recorded immediately after the reconstruction. If there is no increase in flow after the administration of vasodilating agent, the possibility of a technical fault should be entertained. The absolute flow value may help to predict long term graft patency.

Finally, one could implant a flow-probe for continuous flow monitoring during the post operative period, however, this is not necessary because we can do better in this aspect of flow measurement with the Doppler ultrasound instruments.

Dr. John Beal: Dr. Bergan, do you have any comments?

Dr. John Bergan: These two methods, the ultrasound evaluation for pre and post operative management and the electromagnetic flowmeter give the surgeon a quantitative examination of the patient. This aids in assessment of symptoms, as it did in this case, intra-operative evaluation of the reconstruction and long term estimation of success of the operation. ◄

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Relevance in Teaching Basic Medical Sciences—Preliminary Report

(Conitnued from page 35)

the National Boards. It still remains subject to rigorous evaluation. However, we doubt if Dr. Flexner who said, "To call a careful and correct bedside observation clinical and a laboratory examination scientific, as if there were some qualitative distinction between the two, is absurd,"[8] would disapprove. ◄

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Transgrow in Winnebago County

By James Ryder, B.S./Rockford

Transgrow is a medium for the transport and growth of *Neisseria gonorrheae*. This selective culture medium is usually Thayer-Martin or Martin-Lester. Our Transgrow program is mainly designed for the detection of gonorrhea in the asymptomatic female.

In April of 1971, the VD director for the State of Illinois highly recommended that the Winnebego County Department of Public Health have a Transgrow Culturing Program. Upon further questioning it was discovered that no city in Illinois had instituted such a program. The May 14, 1971, *Weekly Report* from the Illinois Department of Public Health stated as its title, "To Diagnose Gonorrhea in Females-Do a Culture." Soon after, the wheels started moving with the administration and the Board of Health taking positive action.

Several factors had to be considered in undertaking such a project. Should an anaerobic incubator be used or would a bell-jar suffice in maintaining the carbon dioxide atmosphere? Can the cultures be mailed from the doctors office to our health department laboratory; or would it be better to have a pick-up service to insure a greater viability of the temperature sensitive bacteria? What would be the most effective way to instruct physicians and nurses in this type of program? After the physician inoculates the culture medium, is there a time factor involved on how long the culture can set in the doctors office before overgrowth may occur on the slant? Last, but not least, can we prove to the taxpayers and Board of Health that cultures detect a higher percentage of asymptomatic gonorrhea than the old method of the Gram-stained smear?

As in all programs, mistakes were made in the initial stages. We tried to limit these problems as much as possible by conducting a pilot program with two physicians in Winnebago County. Dr. I. M. Brechtel, an obstetrician and gynecologist, was asked if she was interested in such a program and she was affirmative. Before our program was started, Dr. Robert E. Whitsitt, a general practitioner, also expressed a deep interest. During June and July, 1,148 samples were cultured and tested in our laboratory.

The literature available to us suggested a vacuum pump to accompany the anaerobic incubator. After our health department chemist, John Foss, experimented with this setup, he found that excessive vacuum or pressure could adversely affect the growth of the gonorrhea colonies. He tested the CO_2 atmospheric content in both bell jar and incubator with a MSA (Mine Safety Appliance) CO_2 testing apparatus and ampules. Bleeding off of 10% of the air in the incubator was an unnecessary step; introducing 10% pure CO_2 directly into the incubator gave us as accurate results. Thus, we found that a vacuum pump was not necessary. It was also concluded that the incubator needed adequate moisture, generally a liberal amount of condensation upon the inner surface of the glass viewing door proved to be a good criterion as to humidity.

During the period prior to June of 1971, the laboratory was receiving Gram-stained smears from physicians to assist them in a clinical diagnosis. After the pilot program, other medical doctors in the community were informed of the program. The medical profession was enthusiastic and interested in this service for their patients. Today, the physicians in Rockford and Winnebago County can receive from the Health Department instructions, media and laboratory service to enable them to diagnose gonorrhea infections. This diagnosis is based on the growth of typical colonies on Transgrow selective media, a positive oxidase reaction, and Gram-negative



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TABLE 1
STATISTICS ON TRANSGROW CULTURES
IN WINNEBAGO COUNTY

DATE	# FEMALE CULTURES	TOTAL % POSITIVE	POSITIVE CULTURES	# SMEARS NEG. WITH POS. CULTURES	% NEG. SMEARS WITH POS. CULTURES
Oct. 71	273	7%	19	4	21%
Nov. 71	289	5%	14	3	21%
Dec. 71	291	5%	16	9	56%
Jan. 72	316	8%	25	7	28%
Feb. 72	440	3%	13	5	38%
Mar. 72	427	4%	17	6	35%
Apr. 72	537	3%	16	7	44%
May 72	590	3%	19	8	42%
June 72	558	7%	39	7	18%
July 72	512	4%	20	8	40%
TOTAL	4,233	5%	198	64	34%

diplococcoid morphology. Gram-stained smears we found were not sensitive enough to rule out a diagnosis of gonorrhea in women except as an adjunct to the cultures. Subculturing by way of sugar fermentation is not done routinely unless requested by a physician as a further check that the bacteria is truly *Neisseria gonorrheae.*

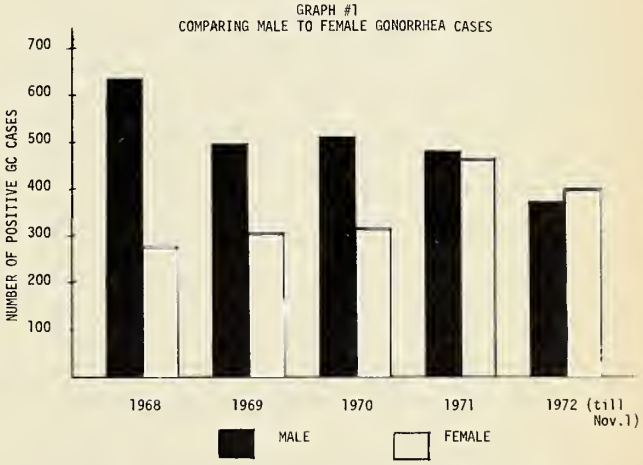
Techniques

The physicians and nurses were personally contacted and informed concerning the various techniques that should be followed. A few of the points stressed included:

1. Store media in refrigerator, but bring to room temperature before inoculation.
2. Hold specimen bottle upright at all times (to maintain the 10% CO_2 atmosphere in the bottle).
3. After the culture has been taken, leave it at room temperature until picked up by the health department.
4. Transgrow media, when inoculated, should be returned to the laboratory within a 96 hour period.
5. A Gram-stained smear is recommended along with the culture for best diagnosis.

Point 5 was included to give a culture-smear statistical comparison. Since August 1, 1972, the doctors and health department felt the smear could be discontinued and the culture alone would be adequate.

Cultures are picked up at the physician's office on a daily basis. Due to the extreme temperature fluctuations experienced in Northern Illinois, we felt it best to have pick up service to keep a higher percentage of the bacteria viable. The cultures are returned to the health department at the end of the daily pickup and placed in a CO_2 incubator. After 18-24 hours of incubation at 34-37°C the cultures are checked and tested. Among the tests is the use of dimethyl-p-phenylenediamine Monohydrochloride to detect oxidase production by micro-organisms. It is used as an aid in differentiating colonies of oxidase producing micro-organisms from those not containing this enyzme. This chemical is helpful in the detection of *Neisseria gonorrheae* colonies growing among colonies of extraneous organisms not inhibited in Transgrow media. Oxidase positive colonies flooded with this 1% aqueous solution of one or two millitliters turn pink within a minute or two and then become black. Oxidase negative colonies do not change color. The solution can be made from liquid or granular stock and should be prepared the same day it is used.



Why do a culture in the first place, won't a smear be adequate? In most cases, statistics show only a 30-50% reliability with the smear for a female that has a gonorrheal infection. In contrast, physicians doing a single cervical culture will detect between 75-85% of the infected female patients. If only a smear had been used on the 4,233 patients tested in Winnebago Coun-

(Continued on page 78)

Rubella Vaccine Complications: Progressions And Variations

By Domingo Leonida, M.D., M.P.H., M.S./Peoria

In a school population of approximately 31,000, rubella vaccine was given to nearly 10,000 children. Children four through six years had the highest risk of complications. When compared with the doses of vaccine distributed in schools, the occurrence of these events suggest a geometric progression. Joint and inverse variations were additional manifestations when contrasting age of the vaccines with the complications among 9,589 children.

Introduction

Human susceptibility to rubella virus is well known. Females of childbearing age comprise a special risk demanding effective interruption of rubella virus transmission.[1] The HPV-77 virus in duck embryo cell culture is currently widely used for mass-inoculations.[2] The natural rubella virus infection may be followed by fever, adenopathy, rash, arthralgia, arthritis, rarely encephalitis.[3] A recent mass rubella vaccination project was carried out among children in a school population exceeding 31,000.[4] The complications to these inoculations were recorded.

Methods and Procedures

Rubella vaccination for elementary and nursery school children began in January, 1970. Lyovac, Meruvax, Rubella Virus Vaccine, prepared in duck embryo cell cultures (Duck cell adapted HPV-77 strain) was administered using disposable needles and syringes. At the beginning of the project, selection of school children for rubella vaccination was made according to the following considerations:

1) High density of susceptibles in the population at large.[5]
2) Mobile segments of the population tended to be high.
3) Preventive medical services tended to have a low priority.
4) High susceptible population density per school class.
5) Housing tended to force persons to live closer to one another.

Vaccination was continued through January 25, 1971, at make-up clinics, to accommodate eligible children in a school district population of approximately 31,000. Rubella vaccination complications were recorded in 73 children 2.5 through 10 years of age (Table 1). Geometric progression was determined. The results were graphed for comparison with reported total complications per dose of vaccine distributed (See Figure 1).

Table 1: DISTRIBUTION OF RUBELLA VACCINE COMPLICATIONS BY AGE, 1970-1971

	AGE (YEARS)							
	3	4	5	6	7	8	9	10
Chills		1	1	2	1	1		
Fever (with other symptom (s))	5	3	1	2	1	1	1	
Adenopathy	6	5	4	2	1		1	
Rash	7	6	3	2	2	1		
Sore throat		1	3	2				
Joint pain		4	3	2	1	2	1	1
Nausea/vomiting		2	3	3	1			
Dizziness			1	1	3	1		
Myalgia		1	2	4	2	6		
Malaise/lethargy		1	2	2				
Headache				4	1			
Soreness at inoculation site (with other symptoms)		2	3	3	2	2	1	
Total Complications	18	26	26	29	15	14	3	1
Rate by Age	18/132	26/132	26/132	29/132	15/132	14/132	3/132	1/132

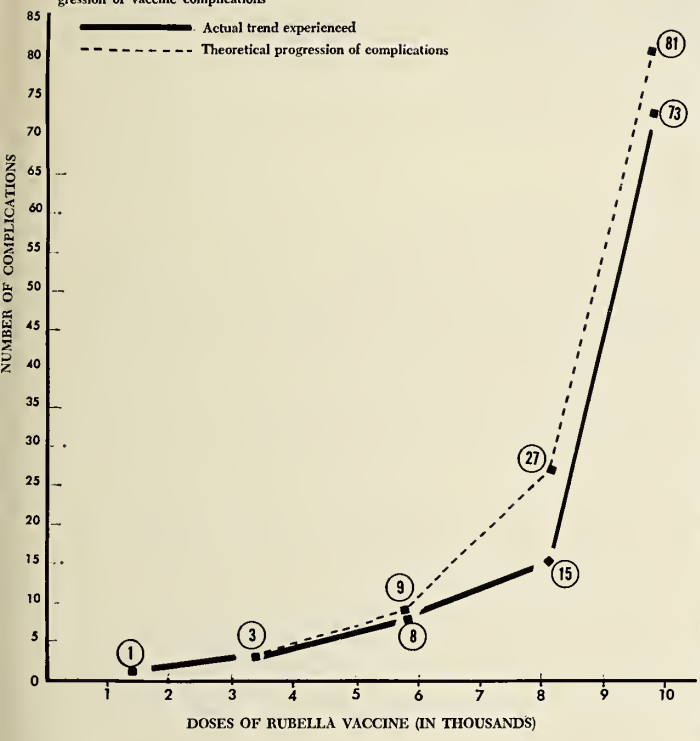
Results

Vaccination complications included adenopathy, fever, joint pain, rash, chills, nausea/vomiting, dizziness, sore throat, lethargy, malaise, myalgia, headache and soreness at site of inoculation (Table 1). Fever alone was not included in the above tabulations. There were a total of 132 complications, occurring singly or in combination, after rubella vaccine was distributed to 9589 children.



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Figure 1: Trend in Rubella Vaccine complications (1970-1971) in contrast to theoretical progression of vaccine complications



Soreness at the inoculation site in combination with other symptom(s) occurred 13 times. Fever in combination with other symptom(s) appeared 14 times. The most common complication was rash (21) singly or in combination. Adenopathy (19), myalgia (15), and joint pain (13) were also frequent complaints. Myalgia complaints involved thigh muscles (50%) and muscles of the upper arm (50%). Joint pain was limited to bilateral knee (transient) involvement. Rash was primarily macular (67%) but some were maculopapular (33%) and pruritic. Adenopathy consisted of mastoid or occipital and cervical lymph adenopathy 2-24 days after vaccination.

Hypersensitivity reaction to rubella vaccine did not occur, although duck or duck feather allergy was highest among private school children (13 per 1,000) and least among preschool children (6 per 1,000).[6]

Discussion

The possibility that concurrent incubation of other microbes could occur with attenuated rubella virus has not been overlooked. When considering these symptoms and signs, differential diagnoses must be reviewed.

No claim is made that all possible complications to the vaccine were tabulated in this report. It is conceded that some complications might not have been reported to the investigators. Only reported complications were included.

The ages at highest risk of rubella vaccine complications were six, five and four years respectively.[7] Less risk of complication was found among the three, seven and eight year olds. Population size vaccinated per age group was very similar, although smaller numbers of children were vaccinated among the three, nine and ten year olds.

Among the complications, rash, adenopathy, myalgia, fever and joint pain were the most common. Headache, malaise/lethargy, dizziness, sore throat and chills were not frequent complaints. None of these were permanent.

In Figure 1 the progression of rubella vaccine complications among preschool and school children was contrasted with a (theoretical) geometric progression. The graphs of the two progressions were very similar.

Joint variation seemed apparent when rash, adenopathy, joint pain and fever (with other symptom) were considered. These findings were most common in the youngest age groups and least in the oldest groups. With increasing age of the vaccinees an inverse variation was observed with rash, adenopathy, joint pain and fever. Myalgia exhibited an inverse variation to these symptoms and signs, when contrasted with decreasing age.

Conclusions

Implications from the data require elaboration. The possibility of concurrent incubation of any microbe in a subpopulation (9589) within a population of 31,000 children is a realistic consideration.

1. Among 9589 children vaccinated with rubella vaccine, four through six year olds exhibited the highest risk of complications.
2. Rash, adenopathy, myalgia, fever, joint pain were the most common findings (singly or in combinations) among 73 affected children.
3. The trend of complications suggest a geometric progression with increasing doses of vaccine distributed.
4. These complications to rubella vaccine manifest joint and inverse variations. ◄

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PULSE ●●● of the doctor's wife

Mrs. Robert Hart, Pulse Editor

From the President's Desk . . .

With the November 9 meeting in Belleville, we finished a most successful round of District Meetings and in this issue will share some of the highlights with you. We realize that our space for communicating with you is limited and want you to know that we are presently making plans for a newsletter direct to you. Hopefully, we will be able to act upon it at the February Board Meeting.

Now that the busy holiday festivities are over, we now find ourselves in the midst of finalizing Convention programming, and so want to remind you to make plans to join us March 25-28 at the Conrad Hilton in Chicago.

Mrs. August (Livia) Martinucci
President

We Met in Chicago

The first district meeting, held in connection with the Chicago Auxiliary on September 12, began the day with an enlightening tour of the AMA facilities. Auxilians were overwhelmed with the complexity of its operations and impressed with the computer system whereby within seconds a professional profile of any doctor registered with the AMA appears on video screen.

Districts 1, 2, 3, 11 were then formally welcomed and introduced. Programs presentations included Lee Ann Elliott, Executive Director of AMPAC, who reminded us that "no matter how good a program is, it can only be successful in a receptive political climate, and that we, the physicians' wives, have begun to make an important impact."

Workshops were headed by Chairmen Mrs. Thomas Glatter, Health Careers; Mrs. John Koenig, Mental Health; and Mrs. Vernon Guynn, Safety. Mrs. Earl Klaren received her new lines of watches available for AMA-ERF proceeds. She announced the fund raising project of the "Doctor's Wife Rose Bush" will be sent out to each area at the seasonally appropriate time. Mrs. Klaren sought approval from members to explore the possibility of becoming a Project Credit State, by which the Auxiliary would get credit for AMA-ERF for our husband's contributions as many other states are now doing.

Safety Chairman Mrs. Guynn displayed literature available through the AMA office and indicated some of the currently emphasized programs in the state, such as the S.O.S., "Safety on the Streets," the Green Safety Lady Program, and the film showing available on "The Unusual Babysitter."

In line with the national emphasis on V.D. Education, Mrs. Oliver Renaud ran a film on the subject, which begins "except for the common cold V.D. is the most rampant communicable disease."

In all, the day was most informative and enjoyable.

. . . and Peoria

Presiding over the combined meeting of Districts 4, 5, 6, 7, 8, was Mrs. Lowell Neveln, 4th District Councilor, in Peoria on October 17. Workshops were conducted on a round robin basis. Mrs. Wendell Roller gave a presentation on "Getting to Know Me, a Doctor's Wife"; Mrs. Robert Hartman spoke and showed a chart on "Getting to Know Your Auxiliary"; Mrs. Thomas Tourlentes led the group on "Getting to Know Our Programs"; and Mrs. Joseph Shanks group discussions enabled the members to get acquainted with each other's community health projects.

Luncheon Speaker was Representative James Nolan, whose informative talk stressed his concern and interests for the medical professions. In discussing the need for further establishing medical schools, he pointed out that presently 55% of our medical students leave the state to establish their practice elsewhere.

Peoria was also the scene for a "Meet Your

Candidates" dinner meeting a week earlier. At the State Convention, Mrs. Martinucci had suggested the auxiliaries hold such meetings during the election year, and Peoria County received much publicity for their efforts in acquainting medical and dental professionals with the candidates for office.

. . . and in Belleville

Districts 9 and 10 enjoyed a memorable day for the last district meeting in conjunction with the Annual Conference of the Southern Illinois Medical Association. Presiding were District Councilors Mrs. Robert Hardin and Mrs. Renato Sociza. Local auxilians presented the comical, but meaningful, membership skit written by Mrs. Willard Scrivner.

Workshops again included Mrs. Shanks, Mrs. Klaren, and Mrs. Taylor. A complimental buffet luncheon was enjoyed and followed by a lovely fashion show of local doctor's wives. The evening program included a banquet for physicians and their wives.

. . . and So

Out of all the meetings we hope the participants will bring back many of the ideas to spur you on to greater efforts and involvements in your county auxiliaries. Again, please contact any of your state officers for any specific information or ideas you may need or can share. There is so much to share with you . . . just let us know of your needs.



Mrs. Alan Taylor, chairman, Legislation, and Mrs. Robert Hardin, 10th District Councilor, discuss the events of the Belleville District Meeting. Mrs. Taylor and Pat Failor, chairman, Public Affairs, along with Mr. Bernie Robinson and Mr. Arvid Hammers of the ISMS Governmental Affairs Department presented a slide program on the legislative process, "The Body Politics," at each of the three district meetings.

Two Minutes for Mental Health

Mrs. John Koenig, chairman, Mental Health, made a presentation at the Chicago District Meeting that we would like to share with you.

"The two minutes allotted for Mental Health seems like a very short time—What can be done for mental health in two minutes? PLENTY! It takes only two minutes to interest your auxiliary in having one of the numerous programs available, such as Drug Abuse, Crisis Centers and Suicide Prevention.

This should be ample time to consent to:

Becoming a volunteer for any of the hot lines (to aid people in distress).

Adopt a "Forgotten Patient" in one of the hospitals.

Visit a home for retarded children and just talk or play with one of them for a short time.

Sponsor the training of volunteers and other personnel who work in the out-patient clinics and half-way houses.

Help a friend by just listening to a problem.

If in two minutes the career of one of our politicians was changed by his announcement of previous therapy, it should take about the same time to help erase the stigma of mental illness, and to become aware that the relatively healthy patient seeks aid when needed.

Two minutes is all you need to vote YES on bills pertaining to mental health. Your auxiliary is briefed on all pending legislation.

Arrange a two minute quiet period for yourself. It's better than a tranquilizer. Plan a hobby. Notice the Sunset. Enjoy the outdoors, birds, flowers. Kiss your husband!!

Say "yes" to the next request to be a bell ringer for mental health. If you can't do that, at least send in your check.

As you can see, the time is running out for mental health. Maybe one of these ideas has stimulated *you* enough to give two minutes for mental health.

45th Annual State Convention
Woman's Auxiliary
March 25-28, 1973
Conrad Hilton—Chicago

The Cooper Quiz

This self-assessment quiz is part of the "Cooper Quiz," a monthly publication of the Department of Medical Education, Cooper Hospital, Camden, N.J. 08103.

1. Although many things may influence the sickle hemoglobin, the sickling process can occur only when the hemoglobin becomes deoxygenated. TRUE or FALSE
2. Anemia in sickle cell disease produces more symptoms than does the thrombosis that occurs. TRUE or FALSE
3. Sudden massive trapping of red cells in the spleen and a mechanical type of ineffective erythropoiesis (a) are (b) are not unique to sickle cell disease.
4. Patients with sickle cell anemia have an increased cardiac output. This is due to hypoxia. TRUE or FALSE
5. If the hematocrit is maintained about 35, endogenous production of sickle cells ceases. TRUE or FALSE

Answers

Reference: The American Journal of Medicine, July, 1972

1. **TRUE.** "The single amino acid mutation of valine for glutamic acid in the beta polypeptide chain of hemoglobin has been shown to have serious consequences for over a quarter of a million people and to place the offspring of many millions of heterozygores in genetic jeopardy. The abnormality permits stacking of hemoglobin molecules in a manner which converts the fluid content of the erythrocyte into a rigid mass which has difficulty passing through the microvasculature. This sickling process can occur only when the hemoglobin becomes deoxygenated." (July 1972, pg. 1, col. 2, para. 1)
2. **FALSE.** "The consequences of the disease in involved subjects includes a constellation of thrombotic episodes which overshadow the manifestations of the hemolytic anemia which is also present. Although there are favorite areas of involvement, virtually all body tissues are in jeopardy, and repeated bouts of local pain and inflammation occur as evidence of focal tissue destruction." (July 1972, pg. 1, col. 2, para. 2)
3. **(a)** "In addition to an occasional aplastic crisis and the development of folate deficiency as occurs in all types of hemolytic anemia, there are two types of anemia unique to sickle cell disease. The first is sudden massive trapping of red cells in the spleen which may occur with infection in childhood and may result in a marked increase in the severity of the anemia within a few hours. The second is the occurrence of what is believed to be a mechanical type of ineffective erythropoiesis. Past studies have indicated that a more complete shutoff of erythropoiesis following transfusion or the inhalation of a high concentration of oxygen occurs in sickle cell anemia than is seen with other hemolytic anemias." (July, 1972, pg. 2, col. 2, para. 2)
4. **FALSE.** "Thus deoxygenation of venous blood, which is so critical in determining the amount of sickling, is nearly normal. The reason for this increased cardiac output is not hypoxia. . . . Indeed cardiac output would not be expected to be sensitive to oxygen tension since it depends more on venous return, viscosity of blood and the regulation of peripheral resistance. A possible cause of the increased output is an expanded blood volume." (July, 1972, pgs. 2-3, col. 2, para. 3)
5. **TRUE.** "The record of treatment in sickle cell disease is not impressive. The only dependable measure has been the replacement of sickle cells by normal red cells. . . . The maintenance of the hematocrit above 35 gm. per cent virtually ends endogenous production of sickle cells. Although beneficial effects have been reported from the administration of fluids and electrolytes, there is no general agreement of its effectiveness. Recently favorable effects have been reported with urea. It appears that the active substance in the urea solution may be a transformation product, cyanate. This substance by its specific binding to the hemoglobin molecule reduces sickling. The usefulness of this substance in the treatment of sickle cell anemia and its safety in man remains to be explored, but the possibility is promising." (July, 1972, pg. 4, col. 1, para. 2)

EDITOR'S NOTE: This is a most interesting and informative short paper on the "Pathophysiologic Aspects of Sickle Cell Anemia"; we recommend it, in its entirety, to you.



new pharmaceutical specialties

by paul dehaen

For detailed information regarding indications, dosage, contraindications and adverse reactions; refer to the manufacturer's package insert or brochure.

Single Chemicals: Drugs not previously known, including new salts.

Duplicate Single Drugs: Drugs marketed by more than one manufacturer.

Combination Products: Drugs consisting of two or more active ingredients.

New Dosage Forms: Of a previously introduced product.

The following new drugs have been marketed:

SINGLE CHEMICALS

ETHRANE Inhalation Anesthetic ℞
Manufacturer: Ohio Medical Products Co.
Nonproprietary Name: Enflurane
Indications: Induction and maintenance of general anesthesia.
Contraindications: Sensitivity to the drug and seizure disorders.
Warnings: See package insert
Dosage: Follow package instructions
Supplied: Bottles 125 and 250 cc.

TRANXENE Ataraxic ℞
Manufacturer: Abbott Laboratories
Nonproprietary Name: Clorazepate Dipotassium
Indications: Symptomatic relief of anxiety
Contraindications: Hypersensitivity to the drug and acute narrow angle glaucoma.
Warnings: Do not use in depressive neurosis or in psychotic reactions, avoid hazardous occupations.
Dosage: Usual daily dose 30 mg. in divided doses; adjust to response of patient.
Interactions: Increased sedation with hypnotic drugs.
Supplied: Capsules, 3.75, 7.5 and 15 mg.

DUPLICATE SINGLE DRUGS

GLUCOSE 40%
OPHTHALMIC Osmotic Agent ℞
Manufacturer: Smith Miller and Patch
Nonproprietary Name: Glucose
Indications: Topical osmotherapy for reducing corneal edema.
Warning: If irritation develops, discontinue drug.
Supplied: Tubes 3.5 gm.

PENAVAR VK Penicillin Derivative ℞
Manufacturer: Parke Davis
Nonproprietary Name: Penicillin Phenoxymethyl Potassium
Indications: Mild to moderately severe infections due to penicillin G sensitive microorganisms.
Contraindications: Previous hypersensitivity to penicillin
Warnings and Precautions: Those usual for penicillin
Dosage: Follow instructions in package insert
Supplied: Tablets, 250 and 500 mg.
For oral solution 125 mg./5 cc.
250 mg./5 cc.

S.A.S.—500 Sulfonamide ℞
Manufacturer: Rowell Laboratories, Inc.
Nonproprietary Name: Salicylazosulfapyridine
Indications: Ulcerative Colitis.
Contraindications: Hypersensitivity to sulfonamides and salicylates; pregnancy at term and during nursing period.
Warnings: May cause agranulocytosis.
Dosage: Follow instructions in package insert
Supplied: Tablets, 500 mg.

SOXOMIDE Sulfonamide ℞
Manufacturer: The Upjohn Company

Nonproprietary Name: Sulfisoxazole
Indications: Sulfonamide susceptible infections.
Contraindications: Hypersensitivity to sulfonamides; pregnancy at term and during nursing period.
Precautions: Impaired renal and hepatic function, severe allergy or bronchial asthma.
Supplied: Tablets, 500 mg.

COMBINATION PRODUCTS

ENDECON Antihistamine cold preparation o.t.c.
Manufacturer: Endo Laboratories, Inc.
Composition: Phenylpropanolamine HCl 25 mg.
Acetaminophen 325 mg.
Indications: Symptomatic therapy of the common cold.
Supplied: Tablets

PANOXYL Emolient ℞
Manufacturer: Stiefel Laboratories, Inc.
Composition: Gel contains:
Benzoyl peroxide 5 or 10%
Polyethylene lauryl ether 6%
Ethyl Alcohol 40%
Indications: As an aid in the treatment of acne.
Contraindications: Hypersensitivity to ingredients
Precautions: Avoid contact with eyes and mucosal membranes.
Supplied: Plastic tubes, 1.5 ounces

PYOCIDIN Otic Antiinfective and antiinflammatory ℞
Manufacturer: Smith Miller & Patch
Composition: Hydrocortisone 5 mg.
Polymyxin B Sulfate 10,000 USP Units
Indications: External otitis, infectious otitis media, infections of mastoidectomy and fenestration cavities.
Contraindications: Tuberculosis, fungal or viral lesions of the skin.
Dosage: 3-4 drops, three or four times daily.
Supplied: 10 cc. bottle with dropper.
Caution: Overgrowth of nonsusceptible organisms is possible.

NEW DOSAGE FORMS

GRIFULVIN V Systemic Fungicide ℞
Manufacturer: McNeil Laboratories, Inc.
Nonproprietary Name: Griseofulvin Microsize
Indications: Various forms of tinea infections.
Contraindications: Porphyria, hepatocellular failure and hypersensitivity.
Warnings: Safety of use in pregnancy not established.
Dosage: Accurate diagnosis of infecting organism essential.
Average daily dose in adults 500 mg.
Children: 5 mg. per pound
Supplied: Suspension, 125 mg./5 cc.

TIGAN INJECTABLE Antinauseant ℞
Manufacturer: Roche Laboratories
Nonproprietary Name: Trimethobenamine HCl
Indications: Control of nausea and vomiting.
Contraindications: Do not use in children.
Warnings: Drowsiness may occur.
Dosage: 2 cc. t.i.d. or q.i.d. intramuscularly.
Supplied: Ampules 2 cc., 200 mg.
Multiple dose vial 20 cc.
Disposable syringes, 2 cc.

TYLENOL Chewable Tablets Analgesic o.t.c.
Tablets Analgesic o.t.c.
Manufacturer: McNeil Laboratories, Inc.
Nonproprietary Name: Acetaminophen
Indications: Relief of fever and pain in children.
Dosage: Age 3 to 6 1 tablet
Over 6 years 2 tablets
Supplied: Tablets, 120 mg.

VIBRAMYCIN
INTRAVENOUS Broad Spectrum Antibiotic ℞
Manufacturer: Pfizer Laboratories
Nonproprietary Name: Doxycycline Hyclate
Indications: Gram positive and negative infections.
Contraindications: Hypersensitivity to tetracyclines.
Dosage: 200 mg. the first day
100 to 200 mg. on subsequent days
Supplied: Vials, 100 mg.



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practice management

Personnel Utilization

By Jim Anstett
Consultant of Professional Business Management, Inc./Deerfield

One key element present in all successful and efficiently run businesses is the proper use of available personnel. This is as true of a medical practice as it is of an international conglomerate. While most will agree to the importance of personnel utilization, few know how to go about implementing it. The purpose of this article is to offer a few suggested avenues for achievement of this goal.

Essential to putting this or any other planned change into effect is the cooperation of your employees. Perhaps you can have a meeting with them and explain what you hope to achieve and why you feel it is necessary. Ask for their cooperation and any suggestions. Make them feel a part of the planning and implementation.

Once you have elicited your employees' cooperation, a good beginning is to have them list their current duties. Taking into consideration who can best perform each job by virtue of ability and training, you should now re-allocate them. The resultant "job descriptions" not only will prove valuable for present duty accountability, but will be helpful when it becomes necessary to replace or add an employee as then you know what qualifications to look for.

In this same vein, it is also advisable to have two people able to cover every duty in the office. This is true even in a two-girl office. The cross-training is extremely valuable in helping during the "rough spots" of sickness or accident, employee turnover, training of new help, etc. Naturally, one person will have the primary responsibility for each function, while another, the secondary accountability.

We all know that most jobs are accomplished best and fastest when they can be done without outside interference. But the ordinary day in a doctor's office is hectic at best. Thus, it is suggested that certain times be scheduled so that many of the tasks can be performed uninterrupted. For example, the beginning of the day, before the doctor starts his office hours, is a good time to have the charts pulled for the day. A day when no patients are to be seen is an ideal time for the aide to catch up on her bookkeepings, billing, insurance forms, etc.

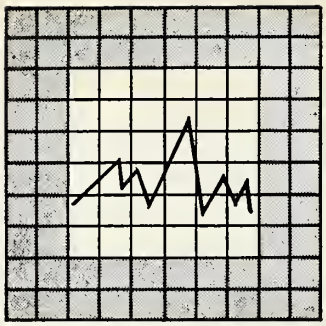
If feasible, the work hours for the aides should be staggered. The irregularity of hours is a common complaint in the physician's office and a frequent reason for job dissatisfaction.

You should also consider the possibility of hiring part-time help. Not only can they assist during the peak load times of the day, but often they are easier to find. This is especially true if someone with special talents is needed only a limited number of hours a week.

Another tool that has been found helpful in properly utilizing your personnel is to map out both your hours and those of your aides. Then decide which hours the aides are needed most and who is to work which hours. It is particularly advisable to do this in a multi-doctor practice as each doctor will find with whom he works best, and vice-versa. Often, it is recommended that a nurse be at the doctor's elbow at all times.

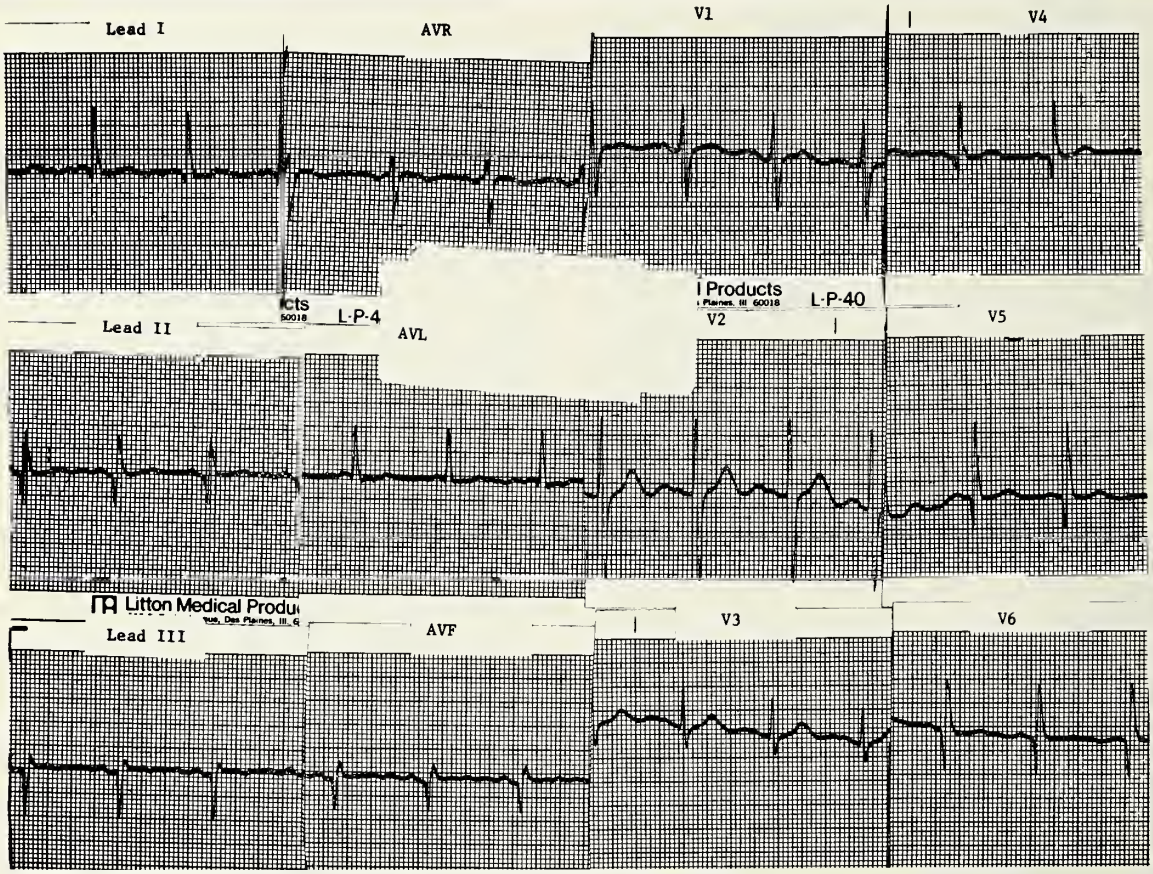
A final word of caution: be wary of overstaffing. Experience has shown that often less work will be accomplished rather than the expected increase. Also, when there is idle time, there is a greater possibility of "office politics" and disharmony among the employees.

In summation, the better an employee is suited to the job, the better she will perform and the better chance there is for a smoothly run, successful practice. ◄



ekg of the month

John R. Tobin, Jr., M.D., M.S., Rimgaudas Nemickas, M.D., Patrick Scanlon, M.D., John F. Moran, M.D. and James V. Talano, M.D./Section of Cardiology, Loyola University Stritch School of Medicine



This patient is a 63-year-old lady who presents because of abdominal pain and constipation for the past few weeks. She has chronic problems with constipation and osteoarthritis. Her history is only vaguely suggestive of cardiac problems in the past. The physical examination is positive for an atrial gallop heard at the apex of the heart, irregular masses in the abdomen thought to be the bowels, and a fecal impaction on rectal examination. An ECG is taken.

1. The ECG is:

A. Normal for age.

B. Positive for right ventricular hypertrophy.

C. Diagnostic of an inferior, lateral, and probably true posterior wall myocardial infarction, old.

D. Represents an acute myocardial infarction as in C.

E. Diagnostic for left anterior hemiblock in the standard leads.

2. Which of the following statements are true:

A. The patient should not have her fecal impaction removed.

B. Rectal examinations are dangerous in this patient.

C. Asymptomatic myocardial infarctions are rare.

D. The patient should be in coronary care unit for treatment of an acute myocardial infarction.

(Answers on page 77)

Pediatric Perplexities Case No. 1

Hemorrhagic Diathesis In A Ten-Week Old Female

By Ruth Andrea Seeler, M.D.
Pediatric Hematologist, Cook County Hospital & Hektoen Institute/Chicago

"Pediatric Perplexities" will be a series of encounterable, but slightly uncommon, pediatric disorders which require prompt diagnosis and specific management for a good outcome. Initially, the series will be based on patients seen by the author at the Cook County Hospital, Division of Pediatrics. The author welcomes suggestions for types of cases that the readers would like to have presented and discussed. This series will alternate with the maternal death studies.

Case Report

A ten-week-old black female was transferred to the Cook County Hospital, Division of Pediatrics, for diagnosis and management of a hemorrhagic diathesis.

The infant was born at term following an uneventful pregnancy, labor and delivery. The neonatal course was uneventful and she was discharged with her mother. The infant did well until seven weeks of age when she developed severe gastroenteritis with dehydration necessitating admission to another hospital. During a two-week hospitalization she was treated with intravenous fluids and antibiotics, and a blood transfusion was given via a femoral cut down. When oral alimentation was resumed the child was placed on a casein hydrolysate formula (Nutramigen) and she received the same formula at home. At the time of discharge, the mother noted that the right elbow was slightly swollen. A few days later the infant developed epistaxis and hematemesis. She was taken back to the other institution where blood was drawn for a CBC. On returning home the vena puncture site continued to ooze and the mother again brought the infant back to the hospital. It was noted that the right elbow was considerably more swollen and there was generalized oozing from the needle puncture and heel puncture sites and the femoral cut down. The child was then transferred to the Cook County Hospital for diagnosis and management.

Physical examination revealed a well-developed, well-nourished, pale female with a continuous oozing from the femoral cut down, needle puncture and heel stick sites, and blood was flowing from both nostrils. The right arm was diffusely swollen from the mid-forearm to the mid-upper arm and the baby resisted all motions at the elbow joint. The remainder of the physical examination was within normal limits. Specifically, there were no petechiae, ecchymoses or enlargement of the lymph nodes, liver, or spleen.

The hematocrit was 22% and the WBC and differential were noncontributory; platelet count was 692,000/cu. mm. with an Ivy bleeding time under 4 minutes; prothrombin time was 96.8 seconds with a control of 12.9 seconds; partial thromboplastin time was over 150 seconds with a control of 32 seconds. Screening tests for fibrinogen by the heat precipitable method and a dilute solution of thrombin were both normal. Considering the clinical setting and the results of the coagulation screening, a presumptive diagnosis of vitamin K deficiency was made and the infant treated with 1 mg of vitamin K_1 (Aquamaphyton). Within an hour there was dramatic cessation of the hemorrhagic phenomena. Individual coagulation assays at the time of admission and 24 hours after vitamin K_1 are shown in the table. The hemoglobin and hematocrit values returned to normal after oral iron administration. The arm regained full range of motion.

Discussion

A generally unrecognized hazard of infantile diarrhea is the potential for the development of vitamin K deficiency severe enough to cause hemorrhagic phenomena. Particularly tragic are



Ruth Andrea Seeler, M.D., is the Pediatric Hematologist at the Cook County Hospital. Dr. Seeler received her M.D. degree from the University of Vermont and then received training in pediatrics and hematology at the Bronx Municipal Hospital and the University of Illinois. Since July 1, 1967 she has been associated with the Cook County Hospital.

TABLE 1
COAGULATION FACTOR ASSAYS

	On Admission	24 Hours
V	100%	98%
II	1%	80%
VII & X (P & P)	1%	75%
VII	1%	100%
IX	1%	100%

the cases resulting in intracranial hemorrhage.

Infants are born with a precarious vitamin K status. At birth the infant has relatively low levels (compared to adult normal levels) of the vitamin K dependent coagulation factors (II, VII, IX, & X). These levels, however, are sufficient to prevent hemorrhage at the time of birth. However, if an infant does not receive exogenous vitamin K, the levels of factors, II, VII, IX, & X decline further and may result in "hemorrhagic disease of the newborn" on the second or third day of life. Infants then have an upswing in the coagulation factor levels due to increased vitamin K intake in the diet and colonization of their gastrointestinal tract by gram negative organisms producing vitamin K. The level of vitamin K dependent coagulation factors approaches that of the adult normal during the six to nine months of life.

The physiological requirement for vitamin K_1 is quite small, probably of the order of 4-10 ugs per day. Vitamin K serum levels will depend upon three factors: (1) the amount of vitamin K in the diet; (2) the vitamin K produced by the gastrointestinal tract; and (3) the absorption of vitamin K. It should be noted that formulas have wide variability in the amount of vitamin K per quart. The lowest levels are found in human milk and in the synthetic formulas which are used following gastrointestinal disorders. Content of vitamin K in cow's milk is adequate.

All infants with acute gastroenteritis, whether or not they are receiving antibiotics, may develop vitamin K deficiency. If the gastroenteritis responds rapidly to intravenous fluids and other supportive management there is usually no need to be concerned, even in the child receiving a low vitamin K content formula. A child with a protracted diarrhea seems to be the one at greatest risk. The increased bowel motility reduces the absorption of both endogenous and exogenous vitamin K. In addition, such infants are frequently changed to a formula with a very low vitamin K content. The situation may be further exaggerated by the administration of antibiotics. Thus, in protracted diarrheal disease, it is not at all uncommon to develop hypoprothrombinemia of sufficient degree to result in frank hemorrhage. However, this patient presented is the exception. The diarrhea had subsided about 10 days earlier and she had not received antibiotics for a similar period. Nevertheless, she had a severe coagulation disturbance.

A hemorrhagic diathesis due to vitamin K deficiency has been documented in otherwise well children who were breast fed or infants receiving a casein hydrolysate or other non-milk formulas.

When pure vitamin K deficiency exists, there is no faster way to correct it than by giving an appropriate dose of the active form of vitamin K_1 (Mephyton or Aquamaphyton). The liver will very rapidly synthesize these factors to such a level that the hemorrhagic phenomenon abates within 1 hour. By 18-24 hours the coagulation factors are usually well within the normal range. There is no need for multiple doses; if one dose of vitamin K does not promptly cause cessation of bleeding more will be useless; 1 mg is many times the physiological amount needed, and larger doses should not be used. ◄

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(Continued from page 53)

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Doctor's News

"VD CHECKLINE" IN OPERATION—A statewide toll-free "VD Checkline" has been put into operation by the Illinois Department of Public Health. The service is intended to assist the young people of Illinois who have questions about venereal disease, or who think they may need treatment but don't know where to obtain it. The checklist number is **800-252-8989.** Volunteers are answering the telephones from noon until 9 p.m., Monday through Friday, and from noon to 5 p.m. on Saturdays.

PROJECT USA LAUNCHED—AMA has developed Project USA to recruit volunteer physicians to fill in the temporary absence of the physicians serving lengthly tours with the National Health Corps. Each location where a National Health Corps physician is assigned has been certified as an area of critical manpower shortage by the local and state medical societies. Those physicians interested to bring medical care to the rural communities and in city areas on a short term basis should contact Project USA, Division of Medical Practice, AMA, 535 N. Dearborn St., Chicago, 60610.

ICCME ELECTS OFFICERS—At the November meeting of the newly organized Illinois Council on Continuing Medical Education, the following were elected as officers: **Richard Byyny, M.D.,** Chicago, president; **J. Ernest Breed, M.D.,** Chicago, vice president; **Robert Fox, M.D.,** Glenview, secretary; and **Dean Bordeaux, M.D.,** Peoria, treasurer.

Activities considered by the Council to work on include: (1) Plans to organize a mini-residency program for practicing physicians in major medical centers, and a related *locum tenens* program for physicians who need this service in order to get away for CME. (2) A survey of Illinois hospitals on their CME activities. (3) Consult with ISMS on providing aid in its activities that are primarily educational in purpose. (4) Seek a role in distributing and encouraging use of self-assessment tests. (5) Coordinate a "Visiting Professor" program. (6) Organize biomedical reading programs. (7) Develop an information system to maintain permanent data on physicians' CME participation. (8) Publish a periodic Newsletter on CME activities for county and specialty societies.

PHYSICIANS IN THE NEWS—New officers of the Illinois Section of the American College of Obstetricians and Gynecologists are **John P. Harrod, Jr., M.D.,** Chicago, chairman and **Merrill W. Huffman, M.D., Urbana,** vice chairman.

Paul P. Youngberg, M.D., Moline, was recently featured in the "Profile In People" column of the *Daily Dispatch,* Moline. Dr. Youngberg, at the age of 78, still maintains a practice in Moline and participates in medical organizations. He has composed a history of medicine in Rock County called "The Doctor's Story."

Adolph J. Rabinovitz, M.D., has been selected to be the Director of Laboratories for St. Anne and St. Elizabeth Hospitals, Chicago. Dr. Rabinovitz holds a teaching appointment as clinical assistant professor in the Department of Pathology at the University of Illinois College of Medicine.

Loyola Stritch School of Medicine has appointed **Suad Shuber, M.B., Ch.B.,** Maywood; **Reena Jabamoni, M.B., B.S., D.G.O.,** Mundelein and **Teresita de Dios Auvila, M.D.,** Hillside, to the Department of Obstetrics and Gynecology. These women will operate the clinic on endocrinology and infertility.

Named as vice presidents of the American Hospital Association are **Madison B. Brown, M.D.; John Sullivan** and **Leo J. Gehrig, M.D.**

NEW FELLOWS OF AMERICAN COLLEGE OF CHEST PHYSICIANS—Recently inducted as Fellows of the American College of Chest Physicians at the annual Scientific Assembly in Denver, Colo., were: **Douglas R. Gracey, M.D.**, Chicago; **Mohammed Jamil, M.D.**, Chicago; **Yoonok Kim, M.D.**, Northbrook; **Rimagaudas Meickas, M.D.**, Maywood; **Donald H. Gustafson, M.D.**, Glen Ellyn; **Henri S. Havdala, M.D.**, Chicago; **Raul A. Blanco, M.D.**, Evanston; **Nicholas J. Gross, M.D.**, Chicago; **August M. Rossetti, M.D.**, McHenry; **Stanley M. Bugaieski, M.D.**, Peoria; **Richard Allyn, M.D.**, Springfield; **Ralph S. Hoover, M.D.**, Freeport; **Robert R. Castro, M.D.**, Ottawa; **George A. Griggs, M.D.**, Scott AFB, Belleville; **Allan E. Solmor, M.D.**, Deerfield; and **D. William Sherrick, M.D.**, Springfield.

NEW ISMS PERSONNEL—Arvid Hammers is the Public Affairs Assistant in the Governmental Affairs Division. He received his B.A. degree from the University of Illinois in political science and earned his M.A. degree from Southern Illinois University in government. Previously, Mr. Hammers worked for the Council of State Governments, midwestern office; Illinois Constitutional Convention and the Illinois Legislative Council.

Appointed as assistant to the Director of Illinois Council on Continuing Medical Education is Mrs. Lois (Donald) Schuhrke. She holds the Bachelor's and Master's degrees in psychology from Indiana University and Ball State University respectively. Formerly, Mrs. Schuhrke worked at Scott, Foresman & Co. and Needham, Harper & Steers.

DR. & MRS. MORRIS FISHBEIN HONORED—"This is Your Life" tribute was paid to Dr. and Mrs. Morris Fishbein by the Chicago Heart Association at the Golden Anniversary Dinner-Dance Celebration and Annual Meeting in October. Dr. Fishbein is the only living founder of the Chicago Heart Association and serves on the Board of Governors; Mrs. Fishbein is on the Women's Council of the Association. Dr. Fishbein served as editor of the *Journal of the Medical Association (JAMA)* from 1924 until 1949 and is author of a syndicated newspaper column and numerous books.

Herman Wing, M.D. Receives Citation



Herman Wing, M.D., (right) Director of physical medicine and rehabilitation for the Illinois Masonic Medical Center, receives the "eagles" denoting his promotion to full Colonel in the United States Army Reserve. Presenting the insignia is Col. Billie B. Hennan, M.D., during the ceremonies held at the 801st General Hospital, 6230 N. Kedzie, Chicago.

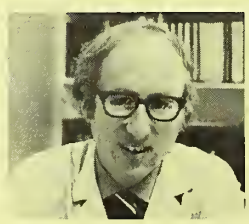
Dr. Wing is one of the nation's few "doctor-lawyers." He is an elected delegate to the Illinois State Medical Society, serves on the ISMS Medical-Legal Council and is a councilor to the Chicago Medical Society. He is also clinical professor of physical medicine at Loyola University's Stritch School of Medicine.

New Associate Dean at Stritch



Bruce H. Bailey, M.D., Oak Park, has been named as Associate Dean for Student Affairs at Loyola University Stritch School of Medicine. He will continue to serve part-time at the Hines VA Hospital supervising psychiatry residents and clerks, and he will also continue as chief psychiatrist for DuPage County Health Department, Mental Health Division, Wheaton.

Chairmanship Appointment for Dr. Coe



Frederic Coe, M.D., has been named chairman of the Renal Division, Department of Medicine, at Chicago's Michael Reese Hospital and Medical Center. Dr. Coe is a graduate of the University of Chicago Medical School and presently a faculty member there.

the view box

LEON LOVE, M.D./CHAIRMAN/DEPARTMENT OF RADIOLOGY
LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE



A 75-year-old white male was admitted to the hospital with abdominal pains, constipation, and distension of three days duration. He was a known cardiac patient under digitalis control.

What's your diagnosis?

1. Carcinoma of the Sigmoid
2. Sigmoid Volvulus
3. Toxic Megacolon
4. Colon Ileus

(Answer on page 77)

★

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investment corner

What About Financial Forecasts?

By Francis E. Kastenholz, Partner
Peat, Marwick, Mitchell & Co./Chicago

Investors usually make their decisions not on the basis of what a company is doing now, but on how the company may be reasonably expected to do in the future. What management forecasts for itself is thus of considerable interest.

In recent months, the Securities and Exchange Commission and other leading voices in the financial community have increased pressure for making the forecasting of sales and earnings a requirement in corporate reporting.

Various informal and unofficial forecasts are being made today, but few believe these are adequate. In the case of management, some forecasts are based more on hope than on an evaluation of the facts. Financial analysts, on the other hand, may have excellent knowledge of the economic environment and the industry being evaluated, but they do not always have knowledge of the actual plans and expectations of management.

As a result of the spotty record of informal forecasting, the investing public may have largely concluded that reasonably accurate forecasts are now attainable. However, many corporations have sophisticated and useful forecasting approaches for internal decision-making purposes. Some of this information can, and should be made available to investors.

The certified public accounting firms, which audit a company's records, are naturally expected to have a viewpoint on whether financial forecasts should be required or optional. This is not easy. Few professionals are so aware of the risks inherent in assuming what the economics of today will produce in the sometimes unpredictable economic climate of tomorrow.

After considerable study, we at PMM&Co., have concluded that we support the implementation of public forecasting. We do so on the basis that financial forecasts provide highly relevant investment information and that the disadvantages of requiring forecasts are outweighed by the advantages. The publication of forecasts is a natural extension of corporate disclosure, and that for forecasts to have credibility they should be independently reviewed.

Standards of preparation and review must be carefully developed and refined as the publication of forecasts will be a major undertaking for most organizations. The potential for legal liability will be greatly expanded with the publicizing of forecast data. Therefore, before this can be done on a widespread basis, the applicable statutes should be amended to define the rights and responsibilities of all parties.

We recommend a cautious and gradual policy of implementing public corporate forecasting on a broad basis.

It appears to us that it will be some time before investors can expect to find a sales/earnings forecast on any security they happen to be considering—a forecast that has been made according to uniform principles and measurements and has been reviewed as valid by independent auditors.

Until such time, the prudent investor will evaluate with considerable caution the increasing number of informal forecasts that will probably be appearing on financial pages of newspapers and in business journals.

One safeguard for the doctor-investor, of course, is to center his consideration on industries with which he has a depth of familiarity and on companies where he knows the management, the product line, the profit margins, the impact of government controls that are current or pending, the likelihood of customer demand, and/or the efficiency of the distribution system. ◄

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RELATIVE EFFICACY

When the Government Decides What Drugs Should Be Prescribed, Is the Patient Better Served?

By Pharmaceutical Manufacturers Association*

By Pharmaceutical Manufacturers Association*

In the fall of 1971, several officials of the Food and Drug Administration began stating that drug manufacturers should provide information on the comparative usefulness of their medications in the treatment of specific conditions. Such "relative efficacy" data they said should be made part of the prescribing information supplied to physicians in drug product labeling.

To persons familiar with the history of the Food, Drug, and Cosmetic Act, the statements from FDA were far from novel. Indeed, the matter had been thoroughly discussed a decade before, when Congress was in the process of enacting the 1962 Amendments to the Act.

At that time, Secretary of Health, Education, and Welfare, Abraham Ribicoff, stated unequivocally that those who had expressed concern that the new law might be used to permit the Federal Government to make relative efficacy judgments had "no basis for such apprehensions." The proposed amendments, he stressed, "would merely require a showing that the new drug described in the application is safe for use and is effective in use, under conditions prescribed, recommended or suggested, in the labeling thereof. This would not require a showing of relatively greater efficacy than that of other drugs. It would merely require that a drug claimed to be effective for a particular purpose had been demonstrated by sound scientific procedures to be effective for that purpose. In short, it must live up to the claims made for it.[1]

When asked specifically if FDA wanted the power to decide relative efficacy, Secretary Ribicoff answered, "We do not seek it. We do not want it. And my testimony indicated we do not intend to pass on it. . . .We do not want to pass on relative efficacy. We do not want to say that drug A is better than drug B or B is greater than C. We are not looking for that at all, and we do not think it is necessary."

Colorado Senator John A. Carroll pursued the matter still further, noting: "you know, some of the doctors have testified that they themselves do not know that drugs operate differently on different people." Mr. Ribicoff agreed, "Absolutely correct. . . . We would not and do not intend and do not want to pass on relative efficacy. This is no power we seek and no power we desire."[2]

It would be difficult to express a more clearcut denial of any intention to act to determine relative efficacy than that of the former HEW Secretary.

Yet it appears that a change in the Department's stated position is intended by some at FDA, apparently on the unsupportable grounds that drug labeling, which does not indicate the product's relative position on a therapeutic scale, is not fully informative, or is somehow false or misleading.

**This article is submitted by Pharmaceutical Manufacturers Association, who invite doctors to submit examples or comments to them on how such a government policy could affect their practice. Write to: C. Joseph Stetler, President, PMA, 1155 Fifteenth St., N.W., Washington, D.C., 20005.*

In order to follow that reasoning, one must assume that a prescribing priority system can be clearly established, and, if so, that the Federal Government should be the judging agency. And that is the crux of the matter.

The question of whether relative efficacy *should* be judged by the government is preceded by the question of whether it *can* be accurately determined. For some drugs, a consensus of expert opinion has been reached. In these cases, the less desirable drug has either vanished (bromides for anxiety, mercurials for diuresis), or has shrunk to prescribing levels justified by the advantages it retains (veratrum for hypertension, sulfonamides for infection). Results of this sort do not require government intervention. On the contrary, it may well be that attempts to impose consensus by fiat rather than by scientific and professional interaction would have had a counterproductive effect.

That leaves many areas of therapy and many groups of drugs for which a consensus has not been reached. Can the government line up, for example, all of the drugs in use against high blood pressure, and meaningfully arrange them in order of efficacy? If so, the physician's task could be simplified immensely. But the answer to this question is *no.*

A number of controlled studies have failed to show any significant difference in efficacy between the major antihypertensive drugs.[3] Yet, while the experts in the field and the prescribing physicians may be at odds not one seems to claim that the major antihypertensive drugs now available are indistinguishable with respect to efficacy or usefulness.

While informed experts decline to make arbitrary judgments about the order in which particular drug products should be used, legislation is now pending (S. 2812, 92nd Congress) that would prevent the marketing of any drug not proven to be better than those already available. Had this bill been in effect when the first thiazide diuretics reached the market, it seems likely that only a handful would be available. Researchers, encouraged to proceed even if their discoveries were only modest, found more than a dozen such products, offering the physician a broad range of activity to meet his patient's needs. And, the availability of these alternatives has doubtless been a factor in the reduction—by about 15% at wholesale—in the price of the average diuretic.

It is thus impossible to justify the relative efficacy requirement from an economic point of view, let alone a medical one. Still, some FDA employees are ready to decide such issues. According to the *Washington Post* of October 24, 1971, "some [FDA] scientists say that the diuretic market is saturated. 'We need another diuretic like a hole in the head" one FDA scientist said."

The question asks itself: Do the American People want FDA deciding when the last diuretic has been discovered, or instead do they wish to see further research leading to improved diuretics encouraged?

In this conncetion, it is noteworthy that early tests

of a drug often fail to uncover some of its best advantages. For example:

- The early research on dimenhydrinate was directed toward its antihistaminic properties; only late in the program was another of its characteristics—its usefulness against motion sickness—noticed;
- The first research using the phenothiazines was in sedation; the drugs' cardinal value in psychoses came to clinicians' attention later;
- Again, the value of isoproterenol in shock, of mafenide acetate in burns, and of lidocaine in cardiac arrhythmia, were not recognized for years after their widespread use for other, less important medical indications.

Had FDA taken the shortsighted position then that one or two good drugs for each therapeutic need should suffice, the drugs just mentioned might never have been marketed.

Because FDA did not make such arguments when these drugs were before them for approval, hundreds of thousands of patients have benefited enormously, in many cases to the extent of recovering the chance to live.

Similarly, there is a difference of medical opinion on the value of antihistamines, corticosteroids and sympathomimetic agents against allergy, with no clearcut consensus on the issue. A lack of unanimity also exists with respect to the therapy of peptic ulcer, where anticholinergics and antacids are used, and in various musculoskeletal conditions, where some advocate muscle relaxants and others order only phenobarbital, much depends on the particular patient.

In such cases, FDA traditionally has followed the lawfully required and prudent course of letting the relative merits of the drug be found through experience, once the general questions of safety and efficacy have been answered. The National Academy of Sciences/National Research Council's 1969 Drug Efficacy Study commented on the point:

> "The final arbiter of the value of a drug is the consensus of the experience of critical physicians in its use in the practice of medicine over a period of years. Approval of a new drug for release to the market is only a license to seek this experience."

That process has been responsible for the large array of steroids of value in contraception, for example, and for the development of new drugs for the management of gout and diabetes. In each of these areas, seemingly trivial differences in the drug not infrequently make major differences to patients—and make arbitrary relative efficacy judgments impossible.

Even in the case of the antibiotics, where it is often assumed that it is easy to match the medication against the disease, it is not uncommon to find authoritative disagreements as to the drugs of first choice (or second and third for that matter).

It must be borne in mind that the physician is not dealing with a disease, which may follow a varied course, but also with an individual patient, whose reactions to the drugs prescribed may be crucial to the outcome of the therapy. Because the individual patient's reactions can make it dangerous to give him what for most patients is the "drug of choice," the physician must be permitted freedom to use his own judgment.

If there is a difference of expert opinion and a need for flexibility in the selection of antibiotics, that need is doubly evident in the selection of many other modes of therapy, where the causative agent or factors may well be less clearly understood, and the characteristics that distinguish one useful drug from another may be considerably less discreet. In the treatment of psychotic disorders, for example, it is widely acknowledged that the relative value of one major tranquilizer as against the others cannot be determined in advance, even though these agents have been under careful and aggressive study for more than 20 years.

Again, the choice of digitalis preparations still presents a challenge, although physicians have studied the use of various forms of these cardiac drugs for about three millennia. Still, according to digitalis authorities Gordon K. Moe, Ph.D., M.D., and Alfred E. Farah, M.D., in *The Pharmacological Basis of Therapeutics,* by Goodman & Gilman (p. 700), "What really matters is not so much the choice or purity of preparations, but the wisdom with which the drug is used by the physician."

The four main factors in a therapeutic relationship are: (1) physician prescribes (2) drugs against (3) disease of (4) the patient. The notion of relative efficacy assumes that for a given disease (factor 3), drugs can be ranked independent of physician (factor 1) and patient (factor 4). This assumption is false. Recent discoveries suggest that the individuality of the patient, and of the physician, play very important roles in determining the effectiveness of drug treatment.

In one review[4] we read:

> "Although it has been recognized for many years that patient-environmental variation is important in determining drug effects, only recently has it been appreciated that genetic factors may play a large part in subtle drug-patient variation. Not all drug-patient variations can be ascribed to genetic factors, but the increasing use of metabolic blocking drugs and enzyme inducing drugs has heightened the clinical awareness of possible subtle pharmacogenic problems."

In the area of mental illness, at least, there are increasing suggestions that the importance and effectiveness of drug therapy vary markedly depending, in part, upon the therapist's experience, values, and personality.[5]

Moreover, there is a real question as to whether the cost of designing meaningful, definitive studies would be even remotely justified by the patient benefits to be expected. In most therapeutic classes, the number of distinct drug entities of value in treating a particular condition is small, frequently less than a dozen. Broadly speaking, the pharmacological effects of the group can usually be described, as is done in any of the standard texts of therapeutics. Using this information, and adding his own background and experience, the physician chooses one compound, basing his choice on the particular therapeutic (or economic) qualities it offers his patient.

Rather than expend limited clinical research resources testing one well-known drug against another, the prudent use of those resources clearly lies in the development of entirely new compounds.

Meanwhile, information on the relative place of marketed drugs, weighing their therapeutic indexes against alternate therapy, is being collected and published in the usual ways. Better data on the overall ratio of desired effects to unwanted ones, which characterizes a given group of compounds when used in a particular situation, assists the physician, not merely in choosing a given drug, but also in selecting from alternative classes of compounds of possible value to the patient.

The provision, by their peers, of information for physi-

cians' guidance is, of course, a far different thing than the provision of even the same information by the federal government, whose "guidelines" more often than not carry the force of law. The question naturally arises: What does it mean when the government—as distinguished from a private body or expert—asserts that Drug A is the one of first choice in Condition A? What is the physician's legal position if, on the basis of his personal experience and educational background, he responsibly disagrees?

The question has been raised many times, and in various ways. Over the years FDA officials have challenged distinguished clinicians and practicing doctors who openly advocate usage of prescription drugs in conditions and at dosage levels not indicated in the FDA-approved labeling.

In 1967, for example, Dr. Walter Modell reported that FDA lawyers were claiming that "publishers, authors and editors who have written, approved and published drug dosages which deviate from those recommended by the FDA are liable for damages. . . ." Objecting to this as a regulation of medicine by fiat, "to which all doctors will have to turn like Holy Writ when they seek help on drugs," Dr. Modell called attention to the danger of letting FDA assume such power. "There must be free and unrestricted expression of opinion and publication of experience with drugs already officially described and delimited in FDA stuffers," he said, "if progress is to be made in therapeutics and if egregious errors, one way or the other, by the FDA, are to be promptly published and rectified."

Moreover, he said, "in the case of every single drug, the determination of actual efficacy, proper dosage, and safe use requires substantial experience by the expert as well as by the general practitioner. It is held by many that it takes about five years before a definitive statement can be made about a new drug."

The issue was rejoined in 1970, when FDA Bureau of Drugs Director Henry Simmons, M.D., advised doctors that whenever they intended to prescribe a medication for use in a manner not approved in the official FDA labeling, they should first file a "Notice of Claimed Investigational Exemption for a New Drug" form.

AMA's Department of Drugs objected vigorously, fearing that "the FDA proposes to approve, forbid, monitor, collect, collate, evaluate, and disseminate results of all clinical experience with drugs in this country that is not consistent with package insert recommendations, regardless of the agency's statutory jurisdiction. . . . We believe the FDA should devote full attention to meeting its statutory obligations, not attempt to expand its statutory grant by regulating the practice of medicine."

AMA stressed that "the physician should always remember a subtle but important distinction: The FDA has no legal authority to approve the uses of marketed drugs; it approves what a manufacturer may say about these uses in its labeling and advertising."[6] Earlier, AMA had published its belief that "the package insert is part of the labeling of a drug and not a legal restriction on the thoughtful and careful use of a drug by an informed physician."[7]

That "subtle but important distinction" has never been acknowledged by the FDA, however, and increasingly, in liability actions brought against physicians, failure to adhere to the labeling recommendations is being portrayed by medical malpractice lawyers as *ipso facto* evidence of wrongdoing. Recognizing this, the American Academy of Family Physicians, in an April 7, 1972 letter to FDA, said that relative efficacy judgments in government-approved labeling would carry the threat of "implied police power, if in no other way by the threat of such regulations being used as a 'club' in malpractice suits." The Academy, which represents 31,000 family physicians, urged that FDA abandon any plans to require relative efficacy statements.

One of the most astute students of the regulatory process in drugs worldwide is Sir Derrick Dunlop, the recently retired head of Britain's Medicines Commission, a sister agency to the FDA. Speaking at a symposium in Geneva in September 1971, Sir Derrick summed up the limits of regulatory power in the area of efficacy rulings by official regulators thus:

> "I do not believe that opinion on matters of efficacy should be formed by bureaucratic bodies, but rather through the free process of scientific publication, debate and undergraduate and postgraduate education. There is a danger that as regulatory agencies arrogate to themselves more and more the duty of dogmatising on the efficacy of medicines, that a so-called learned medical profession will eventually be reduced to signing forms entitling their patients to obtain such medicines as the regulatory agencies say they may have."

In a parallel vein, the Pharmaceutical Manufacturers Association wrote to the Commissioner of FDA on December 23, 1971, asking for a statement of intention from the agency on relative efficacy. "No authority exists in the stated terms of the statutes authorizing these activities by FDA," PMA President C. Joseph Stetler wrote, "nor is there an implied authority which might be derived from the legislative history of the Act." Since pursuance of the plan to require relative efficacy statements "would significantly distort the practice of medicine," Stetler asked for an early clarification of FDA's position.

Four months later, in an address to PMA's Annual Meeting, FDA Commissioner Edwards told PMA that "the physician—and he alone—can judge" the choice of medication, and that "FDA does not intend, through labeling, to preempt his judgment." But then he added that "if all drugs are properly labeled, relative efficacy ceases to be an issue."

The question, of course, is what is proper labeling? It is the general rule for FDA to interpret its regulatory powers very broadly; it may therefore be assumed that some agency personnel might deem it necessary for a "properly labeled" drug product to include relative efficacy information. It is imperative that the professions, the pharmaceutical industry and the public be alerted to the dangers of any official action or unannounced application of such a position by the Food and Drug Administration. There must be general recognition that labeling requirements by FDA in the area of relative effectiveness, to the extent that they are given medical and jurisdiction recognition, represent a fundamental new departure for American medicine, under Federal control, unlike that found in any other national system. In the end, much will depend on how effectively physicians and consumers express their desire to avoid bureaucratic control of this sort, and how well they demonstrate that such procedures do not serve the public interest.

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what goes on

a guide to continuing education

January 23—Chicago Heart Association
Pediatric Cardiopulmonary Intensive Care Nursing Seminar
"Surgical management of the Child and Adolescent Cardiovascular Patient" and "Surgical Management of the Newborn and Infact Cardiovascular Patient."
Contact: Mrs. V. L. Redfern (312) 346-4675.
Hektoen Institute Auditorium, 627 S. Wood St., Chicago

January 24—Martha Washington Hospital
Oral Surgery Lecture
This will be given by Henry Mittleman, D.D.S.
It will begin at 9:00 a.m.
Contact: Fernando Lopez-Fernandez, M.D., Medical Director, Chairman, Continuing Medical Education Committee, Martha Washington Hospital, 4055 N. Western Avenue, Chicago, 60618
Martha Washington Hospital, Chicago

Jan. 28-31—The American College of Obstetricians and Gynecologists
Education Program on Selected Topics of Cancer Management
Fee: General $125, Residents and Fellows $50
Contact: Komanduri K. N. Charyulu, M.D., Division of Radiation Therapy, University of Miami School of Medicine, P.O. Box 875. Biscayne Annex, Miami, Florida 33152

Jan. 31-Feb. 2—The 1973 San Diego Biomedical Symposium
The symposium theme will continue last year's "Innovations in Biomedicine." Technical papers appropriate to the following sessions are invited: Aids to Clinical Care, Modeling and Analysis, Interpretation and Data Reduction, Scanning and Image Processing, Information Engineering, and General Innovations.
Contact: Dr. Robert H. Riffenburgh, Program Chairman, San Diego Biomedical symposium P.O. Box 965, San Diego, CA 92212
Sheraton-Harbor Island Hotel, San Diego, CA

February 7-8—The American College of Emergency Physicians
ACEP Symposium
The program format, designed for all those who have a responsibility in emergency health care, will identify the major components of the emergency care system and show how they fit together to make the system workable. The program will feature seven nationally recognized authorities in emergency medicine who will make individual presentations and many other authorities who will participate in both panel and small group discussions.
Contact: Systems of Emergency Care, Richard Johnson, American College of Emergency Physicians, 241 E. Saginaw St., East Lansing, Michigan
International Hotel, Las Vegas, Nevada

Feb. 8-9—Washington University
A seminar on "Aerosol Inhalation Therapy"
This program is designed to provide an alternative solution for certain problems in inhalation therapy, and to examine the expanded role of aerosol packaging in this field. The latest developments in aerosol packaging and safety for current and experimental inhalation aerosols will be discussed.
Contact: Washington University, Box 1048, St. Louis, MO 63130
Washington University, St. Louis, Missouri

February 9-11—Council on Medical Education of the American Medical Association
69th Annual Congress on Medical Education
There will be various topics covered: The Deviant Physician, The Physician and Medical Discipline, The Physician's Assistant, Changes in Medical Education-Problems and Promises and many others.
Contact: The American Medical Association, 535 N. Dearborn, Chicago, IL 60610
Palmer House, Chicago, IL

February 12—Chicago Heart Association
Golden Anniversary Professional Lecture Series
"Newer Developments in Pre-Coronary Care" will be presented by Bernard Lown, M.D., Boston. It will be co-sponsored by Michael Reese Medical Center.
Contact: Chicago Heart Association, 22 West Madison Street, Chicago, IL 60602
Selz Auditorium—2nd Floor, K & K Building

(Continued on page 77)

Physician Recruitment Program

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program. This is a free service to all physicians.

Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 360 North Michigan, Chicago 60601.

ALBION: General Practitioner. Population 1,800, trade area 13,000 with only 4 physicians in area. Office facilities, financial assistance available. Rural setting, county seat town, expandng economy, hospitals nearby. City Park, swimming pool, tennis courts, etc. Unit school district, Community College 15 minutes. Contact: Don Broster, Citizens National Bank, Albion, 62806, 618-445-2344. (4)

AVON: General Practitioner. Population 1000, trade area 3500 to 4000. Rural practice. Twenty-four bed hospital in town. Office facilities available. Recreational facilities nearby. Excellent area in which to practice and raise a family. Contact: Fred L. Janes, Avon, 61415, 309-465-3883. (4)

BUSHNELL: General Practitioner. Where a doctor can have a family life. Population 3,800. Literally minutes from stocked lakes, water sports. Good hunting. Your dream home costs less. State University close by. Our doctor did Europe all September. Visit there, come home here. Contact: Jack Gordon, Box 150, Bushnell, 61422. 309-772-3141. (4)

CARBONDALE: 25 man multi-specialty in southern Illinois needs Internists, Dermatologist, OB-GYN, Family Practitioners. Generous salary and fringe benefits, early partnership. New, modern building. Developing medical school. Contact: Wayne Given, P.O. Box 1030, Carbondale, 618-549-5311. (4)

CARROLLTON: You can't match or beat the medical opportunities in Greene County, for a Family Physician. Group practice being set-up in a new office building near hospital. For further information write or phone: Drs. Caselton or Wilson or Ray Shoemaker, Carrollton, 62016, 217-942-6946. (4)

CASEY: G.P. wanted to join Medical Center Staff; lab, X-ray, P.T., remote EKG, IPPB, 2 Observ. Rooms, 2 Emerg. Rooms, 24 hr. Emerg. Ser., call every 4th wkend, 1 wk. day, pleasant community, good schools, numerous churches, exceptional recreational facilities, golf course, country club, airport. Contact: Howard G. Johnson, Casey Medical Center, Box 427 Casey, 62420, 217-932-4061. (4)

CHADWICK: General Practitioner. Population 600. Office facilities available. Former physician left practice of twelve years to retire to West Coast. Five minutes from country club and twenty minutes from Mississippi River. Contact: Le Roy Foltz, 329 Marion, Chadwick 61014, 815-684-5128. (4)

CHAMPAIGN-URBANA: Opportunities for Neurologist, Nephrologist, Internists, and Orthopaedist in prospering 30-man group. One-third of doctors under 35. Affluent Big-10 town of 90,000 with top schools and real cultural/recreational attributes. Full Associateship after 18 months on excellent guarantee. Write or call collect: Joseph A. Zalar, Jr., M.D., Christie Clinic, Champaign, 61820, 217-384-1240. (4)

COAL CITY: General Practitioner. Growing community with trade area of 15,000, offers to a physician a completely equipped office. Free for six months. Only one hour from Chicago, three hospitals nearby, and great recreational facilities for leisure. Contact: John Nicoletti, Coal City, 60416, 815-643-8608. (4)

DE KALB: 33,000 Population. University town. Good schools—all religious denominations. Complete office facilities—X-ray & Lab. with 6 physicians—including OB-GYN, General Surgeon, Family Practitioners. Need Internist & Family Practitioner. Financial assistance available. Contact Gordon Graham, 901 N. First, De Kalb, 60115, 815-756-6611. (4)

EFFINGHAM: Service area 60,000—Central Illinois at intersection of I-57 and I-70. G.Ps., OB-GYN, Urology, Orthopedic Surgeon, Internal Medicine, Clinic or solo practice. Progressive community. Contact: Don Kabbes, 503 North Maple Street, Effingham, 62401, 217-342-2121. (4)

EVANSVILLE: General Practitioner. Population 1,000 with a large rural area. We are 15 minutes away from any one of three new hospitals. We stand ready to build to one or two doctors' needs. Also, we have financial assistance available. Contact: Jim Biethman, Box 144, Evansville, 62242, 618-853-2629. (4)

FAIRFIELD: General Practitioners Wanted. Are you bored and want a challenge? Do you want to practice where they don't ask about your diploma, or your specialty? Are you genuinely interested in people and their problems, rather than diseases and cases? If so, come on down to Fairfield and get your feet wet! Write or phone collect: Jerry Vaughan, Box H, Fairfield, Illinois 62837, 618-842-2167. (4)

FLORA: Population 6,000. G.P., Int., OB-GYN, Ortho. Surg., Anesth., Ophth., ENT. Group or Solo Practice. Nine physicians at present. One hundred miles east of St. Louis on Route 50. Financial assistance available. Excellent School system. Outstanding parks and recreational facilities. Visit at our expense. For an appointment contact: Alvin J. Uebinger, Administrator, Clay County Hospital, P.O. Box 280, Flora, 62839, 618-662-2131. (4)

GALESBURG: Galesburg Clinic; population 40,000. Twelve man multispecialty group seeking Ophthalmologist, Orthopedist, Internists, Urologist and Family Practice. New clinic building connected to new hospital. Home of Knox College. Excellent schools, recreational and transportation facilities. A fine opportunity. Contact: L. S. Doyle, Administrator, 320 North Kellogg St., Galesburg, 61401, 309-342-1161. (4)

GENESEO: Ped., OB-GYN, F.P., Orth. Surg., Int. Med. Population 7,000 serving area 30,000 on Interstate 80, 2½ hours from Chicago, 25 miles from Quad-Cities metropolitan area over 300,000. Safe, ideal, small city living, 110 bed ultra modern hospital, excellent schools, recreational facilities. Clement G. McNamara, 210 W. Elk St., Geneseo. Call Collect 309-944-6431. (4)

GIBSON CITY: Int., Ped., OB-GYN, G.P. Rural community with hospital facilities. Half-hour to Champaign-Urbana or Bloomington-Normal or two hours to Chicago loop. Office facilities are available as well as financial assistance if necessary. Contact: Robert E. Jones, Gibson Community Hospital, Gibson City, 60936, 217-784-4251. (4)

HARVARD: General Practitioner. Population, 5250 with trading area 18,000. Only three physicians. Seventy miles from Chicago, 30 miles from Rockford, 75 miles from Madison and Milwaukee and 8 miles from Lake Geneva-Lake Delavan resort area. Sound economic and growing area. Contact: Mrs. Catherine K. Oost, 58 N. Ayer St., Harvard 60033, 815-943-5261. (4)

HERRIN: Int., G.P., ENT, Anthes. Population 10,000-trade area 40,000. Near S.I.U., 90 miles to St. Louis. New offices, modern hospital. Beautiful vacationland, all outdoor sports. Financial assistance and salary guaranteed. Call collect Larry Feil 618-942-4710, Herrin Hospital, Herrin, 62948. (4)

ILLINOIS DRUG ABUSE PROGRAM: Full or part-time work in general medicine, psychiatry, research, administration, or any combination of the above. Ex-

cellent opportunities for treating all types of chemical dependence, as well as carrying out research on medical and psychiatric aspects of the addiction problem. Also, full or part-time work in special units including alcoholism, severe medical and psychiatric problems, and a discreet operation serving pregnant addicts. Contact: Edward C. Senay, M.D., 5700 Lake Shore Drive, Chicago, 60637, 312-955-9800. (4)

LIBERTYVILLE: Family Physician wanted for medical group of three Family Practitioners. Originated in 1952—Incorporated in 1964—Remodeled in 1972. Fringe benefits: hospitalization, pension, profit sharing, bonus and others. Complete office facilities. Please Contact: Mark H. Fields, Jr., M.D., 716 S. Milwaukee Avenue, Libertyville, 312-362-1390. (4)

LITCHFIELD: G.P., OB-GYN, Ped., Int. Population 7300, Trade Area 50,000 in 15 mile Radius. New 134 bed hospital. Midway between Springfield and St. Louis, Mo. on I-55. Good schools. Good recreational facilities. Financial assistance can be arranged. Contact: John Short 723 N. Van Buren, Litchfield, 62056, 217-324-3937. (4)

MACOMB: G.P., Int., Ped. Population 19,000. Home of Western Illinois University. 200 bed open staff hospital. Modern offices available for solo or clinic practice in all specialties. Guarantee plus fringes. No pollution, crime or traffic problems. Rural living with urban culture and recreation. Contact: D. H. Dexter, M.D., Macomb Clinic, Doctors Lane, Macomb, 61455, 309-833-4176. (4)

MARSHALL: General Practitioner. A new medical center now open located 17 miles from Terre Haute where hospital is available. Recreational services include fishing and camping. Another lake is under construction for boating and swimming. Excellent schools. Financial assistance available. Contact: Donald B. Smitley, Cork Medical Center, 410 N. 2nd St., Marshall, 62441, 217-826-2361. (4)

MAYWOOD-DIXON: Population 35,000 and 20,000 respectively. Expanding multispecialty groups, directed towards comprehensive medical care—excellent opportunities for Internist, General Surgeons, Pediatricians, Emergency Room Physicians—now and in the future. Contact: Gene M. Gaertner, M.D., 1908 St. Charles Rd., Maywood 60153, 312-344-5300. (4)

METROPOLIS: Physicians wanted. G.P., OB-GYN. Complete office facilities. Financial assistance available. Modern, well equipped hospital serving tri-county area in scenic southern Illinois. Contact: Charles Russell, Administrator, Massac Memorial Hospital, Metropolis, 62960, 618-524-2176. (4)

MOMENCE: General Practitioner. Population over 4,000. Opening new health center 14 mi. from Kankakee and 50 mi. from Chicago on Route 1. Office facilities available—some financial assistance available. Contact Rachel Simpson, 210 N. Dixie, Momence, 815-472-2751; or George Duguay, N. Dixie Hwy., Momence, 815-472-4833. (4)

MONMOUTH: Service area population: 30,000. Opening for General Practice and General Surgeon with training in Orthopedics and/or Vascular Surgery. Modern well-equipped hospital—141 beds. Near Highways I-74 & I-80. Daily rail to Chicago. Flight service available. Safe place to raise family. Near Medical School. Liberal Arts College. Contact: Roger E. Gurholt, 1000 W Harlem Ave., Monmouth, 61462, 309-734-3141 X 261. (4)

MONTICELLO, IOWA. Trade area 15,000. Need six or seven additional doctors. Presently served by four physicians, all involved in General or Family practice. Could afford some specialties in combination with General Practice. Financial assistance available. Contact John Wild, c/o John McDonald Hospital, Monticello, Iowa, 319-465-3511. (4)

MT. CARMEL: General Practitioner. Population 8,100. Medical service center for 25,000 population. Complete medical facilities. Five doctors at present. Rapidly growing area. All recreational and cultural facilities nearby. Assistance available. Contact: Walter Curry, 20 Lambert Drive, Mt. Carmel, 62863, 618-262-4534. (4)

OLNEY: Weber Medical Clinic, 23 man multispecialty group. Population 100,000+, new building, patient load increased 20%. OB-GYN, Orth., Int., Ophth., Oto., Derm., Urol., 5 weeks vacation, 1 week educational leave per year, pension plan, life insurance, disability. Lovely community, no ecology problems. Contact: David L. Potter, Adm., 1200 N. E. St., Olney, 62450, 618-395-2223. (4)

PEORIA: Population 325,000. Emergency Room position for fulltime physician. Located midway between Chicago, St. Louis, and Iowa City. Excellent minimum salary and benefits. 824 bed community general teaching hospital. Affiliated with University of Illinois Medical School. Illinois State Regional Trauma Center. Contact: Personnel Director, St. Francis Hospital, Peoria, 61603, 309-672-2304 (4)

PINCKNEYVILLE: Population 3500. Opening in small Group-Partnership for Family Physician. Fully accredited hospital. Complete office facilities. No financial investment. Excellent compensation and working conditions. Sixty miles from St. Louis. Good recreational facilities. Contact: Clarence E. Cawvey, M.D., 206 No. Main St. Pinckneyville, 62274, 618-357-2131. (4)

PONTIAC: Population 11,000. 100 miles south of Chicago on Route 66. 10 physicians. Several retiring. Wanted: Family Practitioners, General Surgeon (one on staff), Internal Medicine (none on staff). Paid Emergency Room coverage available. Financing and office space available. Contact: Dale Budde, 610 East Water St., Pontiac, 61764. Call collect: 815-844-5134. (4)

PRINCETON: Population 7,800; County population 38,000. Excellent living conditions; good family community—no problems. Modern 180-bed hospital. Unlimited income for Family Physicians and Pediatricians. 2 hours—Chicago; 1 hour—Peoria & Quad Cities on I-80. Call collect: John Revell, 606 South Main St., Princeton, 61356, 815-872-1255 or 815-875-3292. (4)

PROPHETSTOWN: Small town boy?? If you are a physician interested in General Practice, and want a small town life for your family, then Prophetstown, Illinois may be the place for you. We invite your inquiries. Contact Calvin W. Schuneman, 343 Washington Street, Prophetstown, 61277, 815-537-2301. (4)

QUINCY: OBG, Ped., Ortho., Fam. Prac., Derm., GU, Ind. Med. to join 17-man established clinic. Large modern clinic, many benefits, two well-equipped hospitals. Excellent schools, cultural, recreational advantages. Good family city. Above average earnings. Write or call collect: Mr. Judson C. Green, Quincy Clinic, 1400 Main St., Quincy, 217-222-6550. (4)

RANSOM: General Practice Opening. Death compels sale of practice. Modern equipment and brick building—consists of Doctor's nurses and receptionist's offices, large reception room, laboratory and office-treatment rooms. 80 miles southwest of Chicago. St. Mary's Hospital staff in Streator, practice reaches a 50 mile radius. Contact: Mrs. D. Jones, Ranson, 60470, 815-586-4229. (4)

ROANOKE: General Practitioner. Population 2,050. Opening for one or two physicians. Excellent location for clinic type facility. Financial assistance available. Space available, or will build to suit. Twenty-five miles from Peoria and Bloomington. All recreational facilities nearby. Contact: Elton Ulrich, Savings Building, Roanoke, 61561, 309-923-2831. (4)

ROSICLARE: G.P., Ped. Hospital serves 2 counties-approximately 10,000 people. Three Physicians at present. Office Facilities, financial assistance & housing available. Modern, well equipped hospital. Located on Ohio River and in recreational area. Contact: Loeta Allen, Hardin Co. General Hospital, Rosiclare, 62982.

Call collect: 618-285-6634. (4)

SALEM: G.P., Ped. Growing community with large rural area to serve. Financial assistance available. Fine schools and other municipal services. New 60 bed hospital addition under construction. Eighty miles from St. Louis. Contact: Edris Bachman, 520 Markland, Salem, 62881, 618-548-1944. (4)

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SAVANNA: G.P., Int. 5,000 population on Mississippi River, 40 bed open staff hospital. Exceptional recreational facilities, Excellent schools, Churches of all denominations. Option to practice alone or in partnership. Financial assistance available. Contact: Wm. Dayton, 202 Meadow View Knoll, Savanna 61074, 815-273-2221. (4)

SENECA: Wanted Family Physician—population 2,500, 70 miles southwest of Chicago. No Doctor in town. Beautiful office building and equipment. Offer free rent with option to buy. Guarantee monthly gross. General Surgery knowledge helpful but not necessary. Two new hospitals—12 miles away with country driving. Contact: Marion L. Osborne, 135 E. Lincoln St., Seneca, 61360, 815-357-6172. (4)

SHERIDAN: General Practitioner. One or two doctors for modern medical center. Financial assistance available including part-time staff physician for State institution. Excellent hospital facilities. Good opportunity for doctor who enjoys his family. Contact: John Yuhas, Sheridan, 815-496-2272 days or Alvin Sebby, Sheridan, 815-496-2620 evenings or weekends. (4)

SOUTHWESTERN TERRITORY: General Practitioner, Towns of Brighton, Medora, Piasa, Shipman, combined area population 7500. Office and facilities available, Partnership and or financial assistance available. Five general hospitals in surrounding area, country living, excellent churches, schools, shopping areas, St. Louis and Springfield one hour away. Contact: Kenny Lahr, Piasa, 62079, 618-729-4142. (4)

STREATOR: Population 18,000. Multispecialty group, 7 physicians at present. New air-conditioned facility across from St. Mary's Hospital. Guaranteed minimum salary. Incorporated. Paid vacation and post-graduate study. Excellent insurance benefits. All specialties needed urgently. Contact: Dr. C. T. Hawkins, Streator Medical Clinic, S. C., 104 Sixth Street, Streator, 60364, 815-672-0511 (4)

STRONGHURST: Progressive small town serving large rural area. Close to large advanced medical facilities, recreational facilities nearby. No racial or environmental problems. Contact: Robert Dillon, Stronghurst, 61480, 309-924-6411. (4)

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View Box

(Continued from page 67)

Diagnosis: *Colon Ileus*—Colon ileus is an acute disease entity which simulates mechanical obstruction of large bowel. It can be associated with electrolyte imbalance particularly low potassium levels, cardiac failure, cholecystitis, mesenteric thrombosis, acute pancreatitis, trauma, low spinal disease, Parkinson's disease, and acute gastroenteritis. The dilatation usually involves the entire colon and can be followed in continuity from the cecum to the rectum. A barium enema in these cases reveals no evidence of organic obstruction. In our example, the cecum is markedly distended and as there have been reported perforations of the cecum in these cases, they occasionally have to be decompressed surgically. ◄

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EKG of the Month

(Continued from page 60)

Answers: #1 C #2 None

The ECG shows wide and deep Q waves in leads I, II, III, AVF, V_4 through V_6 compatible with an inferior and lateral wall myocardial infarction. With these findings the tall wide R wave in lead V_1 probably represents a true posterior wall myocardial infarction in addition, i.e. an upside down Q wave in lead V_1 reflecting an infarction on the back of the heart. In some of these cases right ventricular hypertrophy must be ruled out clinically. There are no acute ST-T wave changes seen making it likely that this is an old, healed process. Left axis deviation is present but only to approximately $-20°$. This is still in the normal range which has an upper limit of $-30°$. However, with so much damage already present, some damage to the anterior division of the left bundle branch is likely although not diagnostic here. In the absence of any acute myocardial process, the lady should have her fecal impaction removed and appropriate prophylactic treatment for constipation begun. However, the ECG is still grossly abnormal, compatible with coronary artery disease as described. This lady no doubt had her myocardial infarction asymptomatically. This is not a rare occurrance being seen in 15-20% of patients. Whether these infarctions are actually asymptomatic or these symptoms are ignored or blamed on some other problem like gastrointestinal disease is not known. ◄

What Goes On

(Continued from page 73)

February 16-18—AMA
"Meeting the Challenges of Leadership"
National Leadership Conference
The conference is set to examine priority issues in American medicine. Presidents of state and county medical associations and national specialty societies and their executives have been invited.
Contact: The American Medical Association, 535 N. Dearborn, Chicago, IL

February 20-23—The American Academy of Forensic Sciences
Annual Meeting
More than 200 speakers and panelists, many eminent in their fields, from 35 states and from Canada, Belgium, Sweden and England will take part in the scientific and medico-legal programs being conducted by the Academy's nine Sections. Over 180 technical papers and topics will be presented during the four-day event which will also include the Fifth Annual Meeting of the National Association of Medical Examiners.
Contact: The American Academy of Forensic Sciences, 44 Medical Drive, Salt Lake City, Utah
Las Vegas-Hilton, Las Vegas, Nevada

February 22-24—American College of Hospital Administrators'
16th Congress on Administration
Contact: American College of Hospital Administrators, 840 N. Lake Shore Drive, Chicago, 60611
The Palmer House, Chicago, IL

February 25-27—American Association of Pathologists and Bacteriologists
1973 Meeting
Contact the American Association of Pathologists and Bacteriologists, University of Rochester, 260 Crittenden Blvd., Rochester, NY 14620
Washington Hilton, Washington, D.C.

March 25-28—Illinois State Medical Society and Chicago Medical Society
Midwest Clinical Conference and the Illinois State Medical Society Annual Meeting
ISMS and CMS with invited specialty societies will offer scientific sessions and specialty programs; President's Dinner, Public Affairs Breakfast and the House of Delegates.
ISMS members contact: Mr. Perry Smithers, ISMS Office, 360 N. Michigan Ave., Chicago, 60601.
Conrad Hilton Hotel, Chicago ◄

Transgrow in Winnebago County

(Continued from page 51)

ty, 34% of them would have gone undetected (refer to Table 1). While conversing with Dr. trator for the Winnebago County Department of Public Health, has determined from checking the statistical evidence that the Transgrow Program is uncovering a larger number of the asymptomatic female carriers of gonorrhea. This increase in detection of the infected female will have a large impact in a VD Control Program, and be of great value in the near future to help control our present gonorrhea epidemic. Another amelioration is that culture positive female patients are comprehensively followed to make sure they are treated.

As the program developed, more and more of the cultures being performed were part of a routine physical examination. The family planning clinic conducted by our Health Department uses this routinely as part of their complete physicals. Approximately 70 medical doctors throughout Rockford and Winnebago County are now an integral part of this program. By contributing much time and effort, these dedicated physicians have made a unique step toward helping to reduce the venereal disease rate in our community. ◄

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1. Difco Laboratories: "p-Aminodimethylaniline Monohydrochloride Difco," *Difco Manual*, Ninth Edition, (Copyright 1953 by Difco Laboratory) pp. 296-297.
2. Division of Disease Control, State of Illinois: To Diagnose Gonorrhea in Females—Do a Culture," *Weekly Report*, Week No. 19, ending May 14, 1971.
3. Martin, John E., Jr., B.A., and Arzell Lester, B.A.: "Transgrow a Medium For Transport and Growth of Neisseria Gonorrhea and Neisseria Meningitidis," *Public Health Report*, Vol. 86, January, 1971.
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6. State of Illinois Department of Public Health Division of Laboratories: *Gonorrhea Detection Program:* January, 1971.

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Obituaries

*Bremner, James X., died November 19, 1972.

**Chouinard, C. Robert, died at the age of 82 on December 11. Dr. Chouinard took up residents in Oak Park. He was the founder of Franklin Boulevard Hospital and had offices in Chicago. He was a medical officer in World War I and he was a member of the ISMS 50-year club.

Hughes, Stanley, died December 2 at the age of 60. He had been on the staff of Provident Hospital for 25 years.

*Jakubowski, Casimir L., Chicago, died December 7 at the age of 67. He was a prominent Northwest side physician. He was a former president of the Polish Medical Society.

*Klein, Earnest S., died December 6, at the age of 61. He was a professor of psychiatry and former superintendent of the Elgin State Hospital. He was also on the faculty of the Chicago Medical School as an associate clinical professor of psychiatry at the time of his death. Earlier he worked for 36 years with the State Department of Mental Health.

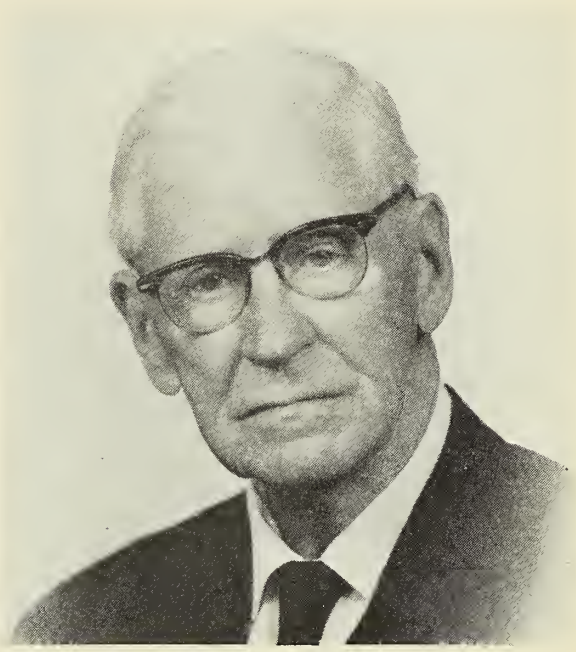
*Krakow, Clarence, died November 18.

*Monaco, Joseph T., died December 5.

*Rabinowitz, Yale, died at the age of 54 on December 7. He was director of the Cell Research Laboratory at Hines Veterans Hospital and associate professor of medicine at Loyola Medical School. He pioneered in the development of methods for the separation and purification of human white blood cells.

**Raymond, Charles, died November 10, at the age of 84. He was a member of the American Academy of Family Physicians and was a staff member of Walther Memorial Hospital.

*Rosenbluth, Paul R., died November 28, at the age of 49. He was professor of neurosurgery at the University of Illinois Medical School. Formerly, he was chief of surgery at Cook County Hospital.



James H. Hutton

James H. Hutton, M.D., past president of the Illinois State Medical Society, died December 8 at the age of 90. He served as president of ISMS in 1940 and, at the time of his death, was the oldest living ex-president. Dr. Hutton was also president of the Chicago Medical Society in 1930.

Dr. Hutton, internist and endocrinologist, maintained offices at 67 E. Madison St., Chicago, for 60 years. During his later years, he concentrated his practice on the causes and prevention of obesity. Earlier, he worked extensively in the field of tuberculosis eradication.

In 1967, Dr. Hutton was elected to the Chicago Senior Citizens Hall of Fame, which recognizes Chicago residents who have successfully pursued "second careers" after reaching the age of 62. At the age of 84, Dr. Hutton was author of a textbook on endocrinology.

As a member of ISMS for 58 years, Dr. Hutton tactfully carried out his duties as chairman of the T.B. Eradication Committee, Committee on Medical Licensure, and the Committee to co-operate with the Osteopathic Group. He was a member of the Committee on Medical Care for Public Assistance Recipients.

Dr. Hutton is the only physician who helped to develop both volumes I and II of the *History of Medical Practice in Illinois.*

A native of Charleston, Dr. Hutton was preceeded in death by his wife, Dorothy. His body was left to Northwestern University Medical School and memorials may be donated to that institution.

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BLUE SHIELD REPORT FOR *Illinois Physicians*

Coverage of Consultation and Technical Surgical Service

Consultations and services of a surgical assistant are in-benefit only when covered in Blue Shield contracts. At present several of our contracts include these benefits. To extend the scope of such benefits for physicians, patients and Blue Shield members, our marketing representatives are striving to broaden existing contracts to include payment for these services.

In April 1972, Blue Shield developed and offered three new indemnity programs on a group basis that pay for the services of a surgical assistant. Three indemnity certificates pay $600, $800 and $1,000 on an indemnity schedule for covered surgical services. The amounts of the indemnity are enumerated in the certificates and are not intended to fix the charge of the physician's services or relate to such charge. Physicians charge their usual fees for service. The patient is responsible for any difference between the physician's fee and the amount specified in the schedule of indemnities.

The dollar limit on the indemnity certificate is the maximum allowance scheduled for a surgical procedure. This means that allowance schedules are set so that the maximum which would be paid for the most complex type of surgical procedure would be $600, $800, or $1,000 depending on the certificate.

Benefits of the New Indemnity Programs

Under the new indemnity certificates, Blue Shield members are protected in part against the cost of a technical surgical assistant when such technical assistance is certified as medically necessary and interns, residents or members of house staff are not available. Payment can be made for up to 20% of the amount specified in the indemnity schedule for the procedure performed.

Payment is also available for a consultation. Payment, not to exceed a scheduled allowance, can be made to another physician when the treatment of a subscriber requires and the attending physician requests a consultation. Payment is limited to one consultation per admission in a hospital or extended care facility and will not be made to a physician who has previously received payment for service under the surgical or obstetrical provisions of these certificates or radiology or pathology consultations.

The scope of benefits of the indemnity programs also includes specified payments for surgery, wherever performed, anesthesia, obstetrical care, in-hospital medical care, emergency medical care, coordinated home care, and in-hospital radiology and pathology examinations when consistent with diagnosis. Blue Shield has offered indemnity programs for over 25 years, and the new certificates add three more choices for groups to meet health care costs.

Exclusion Under U & C Certificates

Most of the basic Usual and Cutomary certificates exclude the services of a surgical assistant. Some groups, however, (e.g., the U.S. Steel and Motors group) have included this benefit, and will pay for the services of technical surgical assistants, if:

(1) No interns or residents were available (2) The hospital had no intern or resident program (3) The procedure was one that required technical surgical assistance.

The surgical assistant must submit a Physician's Service Report, describing his services, the operative procedure performed, and the name of the operating surgeon. It is essential that each physician bill only for the services he personally performed.

A few Usual and Customary certificates provide benefits for a consultation. The amount of the payment is based on the Usual and Customary certificate in force.

BLUE SHIELD INVITES YOU . . .

to visit our exhibit booth at the Midwest Clinical Conference, sponsored by the Chicago Medical Society, the Illinois State Medical Society and participating specialty societies, March 25-28, 1973 at the Conrad Hilton Hotel, Chicago.

Professional Relations Representatives of our Plan will be present to answer questions on Blue Shield and Medicare and provide you with literature on our services.

(This report is a service to the physicians of Illinois)

ASK BLUE SHIELD . . . ABOUT MEDICARE

Physical Therapy Coverage Under 1972 Medicare Amendments

Among the 1972 amendments to the Society Security Act, effective on and after October 30, 1972 are two that apply to out-patient physical therapy services.

The first is in reference to physician certification and recertification of out-patient physical therapy services and says that a physician certification statement showing that a patient requires physical therapy services need not stipulate such services are required on an *out-patient* basis.

The second amendment, also effective October 30, 1972 applies to out-patient physical therapy services rendered in a hospital or "skilled nursing facility". The definition of the latter facility was changed from that of an "extended care facility" by the 1972 amendments. The amendment states that both facilities may furnish physical therapy services to its in-patients who have exhausted their Part A in-patient benefits or who are not otherwise eligible for Part A benefits.

Other conditions that define the eligibility of Medicare patients for physical therapy treatment are that the services:

(1) Be directly and specifically related to an active written treatment regimen designed by the physician after any needed consultation with the physical therapist;

(2) Of such a level of complexity or sophistication or the condition of the patient must be such that the judgement, knowledge and skills of a qualified physical therapist are required;

(3) Are performed by or under the supervision of a qualified physical therapist;

(4) Must be expected to improve significantly the patient's condition in a reasonable period of time or be necessary for the establishment of a safe and effective maintenance program required in connection with a specific disease trait;

(5) Be considered under accepted standards of medical practice to be a specific and effective treatment for the patient's condition; and

(6) Necessary and reasonable for the treatment of the patient's condition.

Services provided for the general good and welfare of the patient such as general exercises to promote overall fitness and flexibility and activities to provide diversion or general motivation are *not* eligible for payment.

The physical therapy services furnished an individual must therefore be reasonable and necessary to his rehabilitation. If an individual's expected restoration potential would be insignificant to the extent and duration of physical therapy services required to achieve that potential, the physical therapy *would not* be considered reasonable and necessary to the treatment of the individual's illness or injury. There must be a medically appropriate expectation that the patient's condition will improve significantly in a reasonable, and generally predictable, period of time based on the assessment made by the physician of the patient's restorative potential after any needed consultation with the physical therapist. Since such expectations may not always prove valid, the realization that restoration will not occur should also be reached in a reasonable and generally predictable period of time.

Maintenance Therapy. In most cases the repetitive services required to maintain function do not require complex physical therapy procedures and, therefore, the judgment and skill of a qualified physical therapist are not required for the safe and effective performance of such services. However, in some cases, as for a Parkinson patient, the judgment and skill of a qualified physical therapist are needed to establish a maintenance program if the program is to be safely carried out and the treatment aims of the physician are to be achieved. In such situations, the initial evaluation of the patient's needs, the designing by a qualified physical therapist of a medically appropriate maintenance program, the instruction of the patient or family members in carrying out the program, and such infrequent revaluations as may be required would be considered eligible physical therapy services.

Physical therapy services are covered under Medicare when rendered in the out-patient department of participating hospitals, skilled nursing facilities and home health agencies. Benefits may also be paid for out-patient physical therapy services rendered at approved clinics, rehabilitation centers, and public health centers when these facilities meet certain requirements.

Certification and Treatment Plan

The physician's certification for physical therapy services should indicate that:

(1) The physical therapy services are or were required by the patient;

(2) A plan for furnishing such service is or was established and periodically reviewed by the physician and

(3) The out-patient physical therapy services are furnished while the patient is under the care of a physician.

Since certification is closely associated with the plan of treatment, the same physician who established the plan must certify to the necessity for out-patient physical therapy services. Certification should be obtained at the same time the plan of treatment is established or as soon thereafter as possible.

When out-patient physical therapy services are continued under the same plan of treatment for an extended period, the physician must recertify at intervals of at least once every 30 days that there is a continuing need for such services and should estimate how long services will be needed. Recertification should be made at the same time that the plan of treatment is reviewed and must be signed by the physician who reviews the plan of treatment.

The plan of treatment, established in writing before treatment is begun, must relate the type, amount, frequency and duration of the proposed physical therapy services and must indicate the diagnosis and anticipated goals. The plan must be reviewed by the physician in consultation with the physical therapist at least once every 30 days. The plan need not be submitted to the Medicare carrier but should be kept with the patient's records. When billing Medicare, the provider should certify that such a plan is on file.

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(cover by Mike White and Associates)

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REGISTERED AIA MEDIA DATA FORM

In any weight loss program:



They're sated with less on PRE-SATE®
(chlorphentermine HCl)

Pre-Sate® (chlorphentermine HCl) offers a valuable anorexic assist to any weight loss program...particularly in the first, critical weeks of management.

Helps curb appetite at mealtime...helps discourage it in-between.

And Pre-Sate has a low potential for abuse.* It helps bring about weight loss comparable to d-amphetamine or phenmetrazine...with little of the CNS stimulation associated with these agents.

*Not described as an abusable drug by The Bureau of Narcotics and Dangerous Drugs.

Pre-Sate® (chlorphentermine hydrochloride)
Caution: Federal law prohibits dispensing without prescription.
Indications. Pre-Sate (chlorphentermine hydrochloride) is indicated in exogenous obesity, as a short term (*i.e.*, several weeks) adjunct in a regimen of weight reduction based upon caloric restriction.
Contraindications. Glaucoma, hyperthyroidism, pheochromocytoma, hypersensitivity to sympathomimetic amines, and agitated states.

Pre-Sate (chlorphentermine hydrochloride) is also contraindicated in patients with a history of drug abuse or symptomatic cardiovascular disease of the following types: advanced arteriosclerosis, severe coronary artery disease, moderate to severe hypertension, or cardiac conduction abnormalities with danger of arrhythmias.

The drug is also contraindicated during or within 14 days following administration of monamine oxidase inhibitors, since hypertensive crises may result.
Warnings. When weight loss is unsatisfactory the recommended dosage should not be increased in an attempt to obtain increased anorexigenic effect; discontinue the drug. Tolerance to the anorectic effect may develop.

Drowsiness or stimulation may occur and may impair ability to engage in potentially hazardous activities such as operating machinery, driving a motor vehicle, or performing tasks requiring precision work or critical judgment. Therefore, such patients should be cautioned accordingly. Caution must be exercised if Pre-Sate (chlorphentermine hydrochloride) is used concomitantly with other central nervous system stimulants.

There have been reports of pulmonary hypertension in patients who received related drugs.

Drug Dependence. Drugs of this type have a potential for abuse. Patients have been known to increase the intake of drugs of this type to many times the dosages recommended.

In long-term controlled studies with high dosages of Pre-Sate, abrupt cessation did not result in symptoms of withdrawal.

Usage in Pregnancy. The safety of Pre-Sate (chlorphentermine hydrochloride) in human pregnancy has not yet been clearly established. The use of anorectic agents by women who are or who may become pregnant, and especially those in the first trimester of pregnancy, requires that the potential benefit be weighed against the possible hazard to mother and child. Use of the drug during lactation is not recommended.

Mammalian reproductive and teratogenic studies with high multiples of the human dose have been negative.

Usage in Children. Not recommended for use in children under 12 years of age.
Precautions. In patients with diabetes mellitus there may be alteration of insulin requirements due to dietary restrictions and weight loss.

Pre-Sate (chlorphentermine hydrochloride) should be used with caution when obesity complicates the management of patients with mild to moderate cardiovascular disease or diabetes mellitus, and only when dietary restriction alone has been unsuccessful in achieving desired weight reduction.

In prescribing this drug for obese patients in whom it is undesirable to introduce CNS stimulation or pressor effect, the physician should be alert to the individual who may be overly sensitive to this drug.

Psychologic disturbances have been reported in patients who concomitantly receive an anorexic agent and a restrictive dietary regimen.
Adverse Reactions. *Central Nervous System:* When CNS side effects occur, they are most often manifested as drowsiness or sedation or overstimulation and restlessness. Insomnia, dizziness, headache, euphoria, dysphoria, and tremor may also occur. Psychotic episodes, although rare, have been noted even at recommended doses. *Cardiovascular:* tachycardia, palpitation, elevation of blood pressure. *Gastrointestinal:* nausea and vomiting, diarrhea, unpleasant taste, constipation. *Endocrine:* changes in libido, impotence. *Autonomic:* dryness of mouth, sweating, mydriasis. *Allergic:* urticaria. *Genitourinary:* diuresis and, rarely, difficulty in initiating micturition. *Others:* Paresthesias, sural spasms.
Dosage and Administration. The recommended adult daily dose of Pre-Sate (chlorphentermine hydrochloride) is one tablet (equivalent to 65 mg chlorphentermine base) taken after the first meal of the day. Use in children under 12 not recommended.
Overdosage. *Manifestations:* Restlessness, confusion, assaultiveness, hallucinations, panic states, and hyperpyrexia may be manifestations of acute intoxication with anorectic agents. Fatigue and depression usually follow the central stimulation.

Cardiovascular effects include arrhythmias, hypertension, or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma.

Management: Management of acute intoxication with sympathomimetic amines is largely symptomatic and supportive and often includes sedation with a barbiturate. If hypertension is marked, the use of a nitrate or rapidly acting alpha-receptor blocking agent should be considered. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendations in this regard.
How Supplied. Each Pre-Sate (chlorphentermine hydrochloride) tablet contains the equivalent of 65 mg chlorphentermine base; bottles of 100 and 1000 tablets.

Full information available on request. PS-GP-31-BW

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Doctor's News

New State Officials

Gov. Daniel Walker has announced the appointment of **Dr. Mark Lepper** as Coordinator of Health Services and Chairman of the Comprehensive Health Planning Board of Illinois. Dr. Lepper has resigned from present positions as executive vice president of Rush-Presbyterian-St. Luke's Medical Center and Dean, Rush Medical College. He will retain a professional appointment in the medical school. **Dr. William F. Hejna** will succeed Dr. Lepper as acting Rush Dean and acting vice president for medical affairs at RPSL. Dr. James Campbell, president, Rush-Presbyterian-St. Luke's Medical Center has announced the appointment of **Dr. John S. Graettinger** as Dean of student and faculty affairs.

Appointed Acting Director of the Illinois Department of Public Health is **Dr. Joyce Lashof,** also of the RPSL Medical Center, Dr. Lashof, a graduate of the Womans Medical College of Pennsylvania, replaces **Dr. Franklin D. Yoder, MPH,** who has served Illinois since 1961.

Illinois Physicians on AMA Councils and Committees

Re-appointed to various AMA councils and committees were **Drs. Newton DuPuy,** Quincy, Council on Health Manpower; **Joseph H. Skom,** Chicago, Committee on Alcoholism and Drug Dependence; **Maurice M. Hoeltgen,** Chicago, Chairman, AMA Disability Insurance Claims Review Committee; **Paul Lazar,** Highland Park, Committee on Cutaneous Health and Cosmetics; **Morton D. Bogdonoff,** Chicago, Chairman, Committee on Hypertension; and **Max Klinghoffer,** Elmhurst, Committee on Community Emergency Services.

Retired AMA council and committee members are **Warren D. Tuttle,** Harrisburg, Council on Scientific Assembly and **Michael Newton,** Chicago and **Stanley L. Harrison,** Evanston, Consultants, Committee on Maternal and Child Care.

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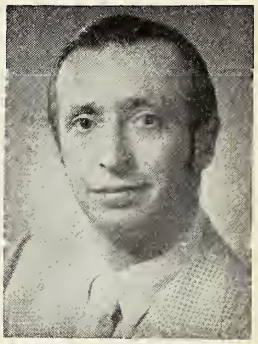
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the presidents page



133rd ISMS Annual Meeting . . .
Learn, Relax and Enjoy

If you had only four days to devote to medically "updating" yourself, how would you use the time?

. . . attend postgraduate classes, lectures or panel discussions in your area of interest?

. . . buff up on the socio-economic aspects of medicine?

. . . re-acquaint yourself with the role today's government is bidding for?

. . . become informed on the drug abuse problem?

Or, you could do all of these things and more! How? By attending the joint meeting of the 133rd ISMS Annual Meeting and Chicago Medical Society's 29th Annual Midwest Clinical Conference.

So mark these dates and the location on your appointment calendar, March 25-28 at the Conrad Hilton Hotel, Chicago . . . and plan on attending!

The information you gain during these four days will benefit you and your patients.

You'll find a diversified choice of excellent instructional courses, lectures, symposia, panel discussions, films and exhibits.

A special day-long course on electrocardiograms . . . a seminar on the trauma program with slides, newsclips and an analysis of the Chicago Illinois Commuter disaster . . . and a health care symposium on the hospital sponsored HMOs, prepaid plans and other HMO proposals will also be held.

Plus the chance to examine over 30 scientific and 130 technical exhibits.

By attending the reference committee meeting, you can have a direct voice in resolutions on which your own ISMS House of Delegates will be voting. Resolutions that will set ISMS policy . . . resolutions that will directly affect YOUR medical future. The House will convene Sunday, March 25 at 3 p.m. . . . Stop in and see it in action.

Also, on Monday, take time to attend the Drug Abuse Seminar sponsored by the National Training Center on Drug Abuse. The program will include pharmacology, epidemiology, the street scene, poly-drug, a report on state treatment facilities and training sessions for physicians.

Tuesday, March 27 you're all invited to attend the Annual Public Affairs Breakfast . . . and the President's Dinner that evening.

For your wife's pleasure, the Auxiliary has planned many educational and entertaining activities. Not to mention Chicago's fine stores, restaurants and cultural activities.

As you can see . . . it's a golden opportunity to learn, relax and enjoy yourself.

I hope you'll plan on attending . . . remember March 25-28 . . . the combined meeting of the ISMS Annual Meeting and Chicago Medical Society's Annual Midwest Clinical Conference.

Frank J. Jirka Jr. M.D.

In Gonorrhea

Injection WYCILLIN®

(sterile procaine penicillin G suspension) Wyeth

Penicillin in large doses remains the drug of choice in therapy of gonorrhea. Among penicillins, first choice recommended by the national Center for Disease Control for parenteral therapy of uncomplicated gonorrhea is aqueous procaine penicillin G.

Administration of 4.8 million units together with 1 gram oral probenecid, preferably given at least 30 minutes prior to injection, is recommended in treatment of uncomplicated gonorrhea.

Indications: In treatment of moderately severe infections due to penicillin G-sensitive microorganisms sensitive to the low and persistent serum levels common to this particular dosage form. Therapy should be guided by bacteriological studies (including sensitivity tests) and by clinical response.

NOTE: When high sustained serum levels are required use aqueous penicillin G, IM or IV.

The following infection will usually respond to adequate dosages of intramuscular procaine penicillin G.—*N. gonorrhoeae:* acute and chronic (without bacteremia).

FOR DEEP INTRAMUSCULAR INJECTION ONLY.

Contraindications: Previous hypersensitivity reaction to any penicillin.

Warnings: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy.

Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen and intravenous corticosteroids should also be administered as indicated.

Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents e.g., pressor amines, antihistamines and corticosteroids.

Precautions: Use cautiously in individuals with histories of significant allergies and/or asthma.

Carefully avoid intravenous or intraarterial use, or injection into or near major peripheral nerves or blood vessels, since such injections may produce neurovascular damage.

A small percentage of patients are sensitive to procaine. If there is a history of sensitivity, make the usual test: Inject intradermally 0.1 cc. of a 1 to 2 percent procaine solution. Development of an erythema, wheal, flare or eruption indicates procaine sensitivity. Sensitivity should be treated by the usual methods, including barbiturates, and procaine penicillin preparations should not be used. Antihistaminics appear beneficial in treatment of procaine reaction.

The use of antibiotics may result in overgrowth of nonsusceptible organisms. Constant observation of the patient is essential. If new infections due to bacteria or fungi appear during therapy, discontinue penicillin and take appropriate measures.

If allergic reaction occurs, withdraw penicillin unless, in the opinion of the physician, the condition being treated is life threatening and amenable only to penicillin therapy.

When treating gonococcal infections with suspected primary or secondary syphilis, perform proper diagnostic procedures, including darkfield examinations. In all cases in which concomitant syphilis is suspected, perform monthly serological tests for at least four months.

Adverse Reactions: (Penicillin has significant index of sensitization) skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported. (See "Warnings.")

As with other antisyphilitics, Jarisch-Herxheimer reaction has been reported.

Administration and Dosage: Administer only by *deep intramuscular injection,* in upper outer quadrant of buttock. In infants and small children, midlateral aspect of thigh may be preferable. When doses are repeated, vary injection site. Before injection, aspirate to be sure needle bevel is not in blood vessel. If blood appears, remove needle and inject in another site.

Although some isolates of *Neisseria gonorrhoeae* have decreased susceptibility to penicillin, this resistance is relative, not absolute, and penicillin in large doses remains the drug of choice. Physicians are cautioned not to use less than recommended doses.

Gonorrheal infections (uncomplicated)—Men or Women: 4.8 million units intramuscularly divided into at least two doses and injected at different sites at one visit, together with 1 gram of oral probenecid, preferably given at least 30 minutes prior to injection.

NOTE: Treatment of severe complications of gonorrhea should be individualized using large amounts of short-acting penicillin. Gonorrheal endocarditis should be treated intensively with aqueous penicillin G. Prophylactic or epidemiologic treatment for gonorrhea (male and female) is accomplished with same treatment schedules as for uncomplicated gonorrhea.

Retreatment: The National Center for Disease Control, Venereal Disease Branch, U.S. Dept. H.E.W. recommends:

Test cure procedures at approximately 7-14 days after therapy. In the male, a gram-stained smear is adequate if positive; otherwise, a culture specimen should be obtained from the anterior urethra. In the female, culture specimens should be obtained from both the endocervical and anal canal sites.

Retreatment in males is indicated if urethral discharge persists 3 or more days following initial therapy and smear or culture remains positive. Follow-up treatment consists of 4.8 million units. I.M. divided in 2 injection sites at single visit.

In uncomplicated gonorrhea in the female, retreatment is indicated if follow-up cervical or rectal cultures remain positive for *N. gonorrhoeae.* Follow-up treatment consists of 4.8 million units daily on 2 successive days.

Syphilis: all gonorrhea patients should have a serologic test for syphilis at the time of diagnosis. Patients with gonorrhea who also have syphilis should be given additional treatment appropriate to the stage of syphilis.

Composition: Each TUBEX® disposable syringe 2,400,000 units (4-cc. size) contains procaine penicillin G in a stabilized aqueous suspension with sodium citrate buffer, and as w/v approximately 0.7% lecithin, 0.4% carboxymethylcellulose, 0.4% polyvinylpyrrolidone, 0.01% propylparaben and 0.09% methylparaben. The multiple-dose 10-cc. vial contains per cc. 300,000 units procaine penicillin G in a stabilized aqueous suspension with sodium citrate buffer and approximately 7 mg. lecithin, 2 mg. carboxymethylcellulose, 3 mg. polyvinylpyrrolidone, 0.5 mg. sorbitan monopalmitate, 0.5 mg. polyoxyethylene sorbitan monopalmitate, 0.14 mg. propylparaben and 1.2 mg. methylparaben.

Denise has VD.

Let's keep it from getting around.

Actual new cases of infectious syphilis apparently reached the 100,000 mark during the past year; new cases of gonorrhea, more than 2.5 million. That VD is rampant again is due, in large part, to the multiple contacts of teenagers like Denise.

By administering adequate doses of the recommended types of penicillin, you can usually cure VD in the beginning stages. And destroy another link in the chain of infection.

CONVENTION '73



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	David Holberg	Richard Hawkins
	Herman Lustigman	Richard Dolan
	Eugene Pitts	John Andrews
LaSalle	William Erkooen	Robert Rieman
Lawrence	Gilbert Miller	R. C. Kirkwood
Lee	Donald Edwards	Charles H. Lesage
Livingston	Karl Deterding	N. Kothari
Logan	James B. Borgerson	Gilbert E. Blaum

County	*Delegate*	*Alternate*
Macon (2)	A. J. Kissel	R. D. Miller
	C. L. Sandburg	J. Schrodt
Macoupin	Lee Johnson	David Largey
Madison (2)	Edward DuVivier	E. Ragsdale
	George T. Wilkins	George F. Dietz
Marion	Walter P. Plassman	W. W. Davidson
Mason	Jack Means	Dario Landazuri
Massac	*Not Sending Delegates*	
McDonough	D. I. Mazor	S. M. Gines
McHenry	George Alvary	Edward Chereck
McLean	Loren Boon	Robert Reardon
Menard	Paul M. Purdy	Robert Schafer
Mercer	R. N. Svenson	Monty McClellan
Monroe	Joseph Werth	I. M. Kremar
Montgomery	Roger McFarlin	James T. Foster
Morgan-Scott	Robert R. Hartman	E. C. Bone
Moultrie	*Not sending Delegates*	
Ogle	Robert Dearborn	Don Hinderliter
Peoria (3)	G. W. Gielbehausen	Fred J. Heinzen
	Henry A. Bolot	Robert A. DeBord
	Hugh J. McMenamin	John W. Berney
Perry	C. E. Cawvey	James Stotlar
Piatt	George G. Green	Marion D. Kinzie
Pike	Meyer Shulman	Gene Goodman
Pulaski	A. L. Robinson	Marvin F. Powers
Randolph	O. W. Pflasterer	J. M. Whittenberg
Richland	C. A. DeKovessey	John S. Dunker
Rock Island (2)	Theodore Grevas	Richard Phillis
	C. P. Cunningham	Wm. Dogherty
St.Clair (3)	Julian Buser	Charles R. Frazer
	John S. Hipskind	Peter J. Soto
	H. Frank Holman	Dale Rosenberg
Saline-Pope-Hardin	Warren D. Tuttle	Earl Walker
Sangamon (3)	William W. Curtis	G. K. Greening
	Earl D. Donelan	Homer M. Kimmich
	Edward G. Ference	Henry F. Rohs
Schuyler	Henry C. Zingher	Russell Dohner
Shelby	Duncan Biddlecomb	H. H. Pettry
Stephenson	E. L. Vickery	Jaime Ballesteros
Tazewell	N. A. Wright	Daniel E. Baer
Union	*To Be Elected*	*To Be Elected*
Vermilion	A. M. Taylor	J. L. Gulick
Wabash	Roger Fuller	Ernest Lewinstein
Warren	Russell Jensen	Richard Icenogle
Washington	Jerry L. Bequelin	Charles Longwell
Wayne	C. J. Jannings	Edward Talaga
White	*To Be Elected*	*To Be Elected*
Whiteside	John F. Hubbard	C. Mueller
Will-Grundy (3)	Robert J. Becker	Robert Kramer
	Guy A. Pandola	John H. Kendall
	Barry S. Seng	Michael Greenwald
Williamson	Herbert V. Fine	Roger Hendricks
Winnebago (4)	Robert Heerens	R. J. Rosenberg
	E. T. Leonard	D. P. Feeney
	F. M. Riordan	Donald Wrork
	Robert Behmer	P. J. Seward
Woodford	Hans W. Riggert	J. C. Pheifer
Student Amer. Medical Association	Michael Hughey	Jeff Waitzman

CHICAGO MEDICAL SOCIETY

Delegates	*Alternate Delegates*
Aux Plaines Branch	
John S. Hyde	Allison L. Burdick, Jr.
Chester B. Thrift	Robert C. Muehrcke
William Ashley	John W. Tope
C. Otis Smith	Meredith B. Murray
Joseph B. Moles	Martin W. Green
Roland Kowal	Arthur G. Lawrence
Allison L. Burdick, Sr.	Gustav A. Hemwall
Everett E. Nicholas	Richard H. Blankshain
Calumet Branch	
To Be Elected	
Douglas Park Branch	
Edward A. Razim	Frank Jirka, Jr.
Colman J. O'Neill	Robert F. Cesafsky
Loren B. Horton	Gerald Neskodney
Charles Mrazek	Gilbert R. DeMange
Raymond Nemecek	Miles Cermak
Englewood Branch	
Edward Krol	John Krolikowski
Frank Kwinn	Joseph Patka
F. Saletta	Stanley Bunrys
William Nainis	John Meyer
Nathan Pitaro	John Dudek
North Suburban Branch	
Leon L. Ampel	Harley Sigmond
Richard Stalzer	Carl Johner
To be elected	Myles P. Cunningham
William J. FitzPatrick	Jerome T. Paul
John W. O'Donnell	George A. McDermott
Howard C. Burkhead	James Holland
David W. Cromer	Thomas G. Soper
C. Malcolm Rice, Jr.	John M. Bailey
John L. Savage	Thomas Stafford
James W. Ford	James R. Dillon
Irving Park Suburban Branch	
Herman Wing	Earl Solon
Fred Tworoger	Theodore Johnson
Lawrence Hirsch	Sanford Franzblau
Martin P. Meisenheimer	Thomas Conley
Allen Hrejsa	George W. Holmes
George C. Turner	Alexander Ruggie
Arthur T. Haebich	A. Clementi
Vincent C. Sarley	Philip H. Heller
Alfred J. Faber	Peter Pleotis
Jackson Park Branch	
Julius E. Ginsberg	William P. Mavrelis
Loran H. Dill	Lester O'Dell
Murry M. Paull	Myron M. Hirskind
Mathew W. Kobak	Nerissa Singh
Henrietta Herbolsheimer	Helen Cook Newman

Delegates	*Alternate Delegates*
North Shore Branch	
Philip R. McGuire	H. Kenneth Scatliff
Herschel Browns	Samuel T. Gerber
George C. Markoutsas	Lief Bjornssen
Joseph R. DeCaro	William B. Stromberg, Jr.
William O. Ackley	Frank Hussey
John B. Murphy	Jack D. Clemis
David T. Petty	Steven J. Spinuzza
George H. Irwin	Danford Chamberlain
Burton J. Soboroff	Joseph H. Skom
Clarence A. Norberg	Rocco V. Lobraico
North Side Branch	
Vincent C. Freda	Richard Perritt
Jack Williams	Benjamin F. Lounsbury
Erwin M. Patlak	I. Pat Bronstein
Clifton L. Reeder	Joseph Schifano
James P. FitzGibbons	Randolph W. Seed
Michael H. Boley	Joseph C. Sherrick
Roland R. Cross	Daniel Ruge
Samuel L. Andelman	C. Larkin Flanagan
William A. Hutchison	Bernard T. Peele
Coye C. Mason	Ray Silins
Northwest Branch	
Alfred A. Zanette	I. P. Lombardo
Louis A. Wajay	Alfonso Diaz
E. J. Kotanyi	N. J. Kupferberg
Michael J. Kutza	M. A. Rydelski
South Chicago Branch	
Arne E. Schairer	Jere Freidheim
Morris T. Friedell	Maynard I. Shapiro
Anthony G. Cesare	Vincent Costanzo
South Side Branch	
Kermit T. Mehlinger	Otto J. Keller
Alfred Klinger	Jacob M. Epstein
Robert R. Mustell	Aldo Pedroso
Southern Cook County Branch	
Harold L. Jensen	C. R. Heidenreich
Peter I. Eagan	Joseph Goreck
Charles O. Sandberg	Conrad J. Urban
Stock Yards Branch	
Edwin J. Lukaszewski	Frank J. Nowak
West Side Branch	
Eugene T. Hoban	William J. Tansey
Anna Marcus	Henry B. Okner
J. Robert Thompson	Louis S. Varzino

At-Large

Charles J. Weigel
Charles P. McCartney
Fredric D. Lake
A. Everett Joslyn
Alfred J. Faber

Agenda

1973 House of Delegates

Paul W. Sunderland, *Speaker*
Andrew J. Brislen, *Vice-Speaker*

FIRST SESSION

3:00 P.M. Sunday, March 25, 1973

International Ballroom South

Conrad Hilton Hotel—Chicago

1. Call to Order—Speaker Paul W. Sunderland, M.D.

2. Invocation

3. Report of Credentials Committee—Roll Call

4. Report of Committee on Rules and Order of Business

5. Approval of the minutes of the March, 1972, meeting

6. Memorial Service for Deceased members since March, 1972 Conducted by Jacob E. Reisch, M.D., *Secretary-Treasurer*

7. Reports of Special Guests
 A) President, Women's Auxiliary to ISMS
 Introduced by husband, August Martinucci, M.D.
 B) Pesident, American Association of Medical Assistants, Illinois Society
 Introduced by Philip G. Thomsen, M.D.

8. Introduction of Special Guests
 President-Elect, AMA Woman's Auxiliary
 Mrs. Willard C. Scrivner
 Officers of other Medical Societies
 by Dr. Frank J. Jirka, Jr., *President*

9. Presentation of AMA-ERF check to representative of Illinois Medical Schools
 by—Dr. Frank J. Jirka, Jr.

10. Presentation of Special Awards
 Edwin S. Hamilton Teaching Award

11. The President's Address
 Dr. Frank J. Jirka, Jr.

12. IMPAC Report
 V. P. Siegel, M.D., *Chairman*

13. Report of Executive Administrator
 Roger N. White

14. Introduction of AMA Delegates & Alternates—Carl E. Clark, M.D., *Chairman of Delegation*

15. Remarks of Speaker
 Introduction of New Delegates

16. Reference Committees—announcement of changes

17. Resolutions and Supplementary Reports
 a) Changes of those in handbook
 b) Late resolutions
 (1) Those accepted for introduction
 (2) Those not accepted for introduction
 c) Supplementary report assignment

18. New Business—Announcements
 IMPAC meeting 3:00 P.M.—Monday, March 26
 Down State Caucus 4:00 P.M. Monday, March 26
 Delegates Buffet—5:30-6:30—Room
 Reference Committees—7:00 P.M.

19. Recess until 2:00 P.M. Tuesday, March 27, 1973

SECOND SESSION

2:00 P.M. Tuesday, March 27, 1973

Conrad Hilton Hotel—Chicago

1. Call to Order by the Speaker—Paul W. Sunderland
2. Invocation
3. Roll Call
4. Report—Committee on Rules and Order of Business
5. Announcements
6. Introduction—Guests and Visitors
7. Reports of Reference Committees
 a. Constitution and Bylaws
 Howard Burkhead, M.D., *Chairman*
 b. Officers and Administration
 Roland A. Kowal, M.D., *Chairman*
 c. Finances, Budgets and Publications
 James A. McDonald, M.D., *Chairman*
 d. Governmental Affairs
 William O. Ackley, M.D., *Chairman*
 e. Education and Manpower
 Ralph G. Ryan, M.D., *Chairman*
 f. Environment, Community, Public and Mental Health
 John Hipskind, M.D., *Chairman*
 g. Economics and Social Services, Peer Review
 Joseph B. Moles, M.D., *Chairman*
 h. Public Relations and Miscellaneous Business
 E. T. Leonard, M.D., *Chairman*
8. Unfinished Business
9. New Business—Announcements
10. Recess until 2:00 P.M. Wednesday, March 28, 1973

THIRD SESSION

2:00 P.M. Wednesday, March 28, 1973

Conrad Hilton Hotel—Chicago

1. Call to Order by the Speaker—Paul W. Sunderland
2. Invocation
3. Roll Call—Report of Credentials Committee
4. Report—Committee on Rules and Order of Business
5. Induction of Willard C. Scrivner, *President-Elect* into office of president by Frank J. Jirka, Jr.
6. Address of President Scrivner
7. Introduction of guests and visitors
8. Announcements—Presentation of Awards
 Journalism Fellowship
 Scientific Exhibit
9. Reference Committees—Remaining Reports
10. Elections

 Report of Nominating Committee

 a) President-Elect (CMS)

 b) 1st Vice President (Downstate)

 c) 2nd Vice President (CMS)

 d) Secretary-Treasurer (Downstate)

 e) Speaker of House (CMS)

 f) Vice Speaker (Downstate)

 g) Trustees

DISTRICT	Terms Expiring
3rd	David S. Fox
3rd	Robert T. Fox
3rd	Frederick E. Weiss
4th	Fred Z. White
5th	A. Edward Livingston
7th	Arthur F. Goodyear
8th	Eugene P. Johnson

 h) Delegates to AMA to take office Jan. 1, 1974, and serve to Dec. 31, 1975.
 Terms Expiring:
 Jack Gibbs
 Theodore Grevas
 Morgan M. Meyer
 Edward A. Piszczek
 Harold A. Sofield
 Philip G. Thomsen

 Alternate delegates to AMA
 Terms Expiring:
 Herschel Browns
 William M. Lees
 George Shropshear
 Paul W. Sunderland
 Glen Tomlinson
 Charles K. Wells
11. Fixing of per capita dues for 1974
12. Selection of meeting place and time for next annual meeting
13. Unfinished business
14. New Business
15. Adjournment, *sine die*

1973 Committees of the House of Delegates

COMMITTEE ON CREDENTIALS

Edward DuVivier, *Co-Chairman,* (DS)
Fredric D. Lake, *Co-Chairman,* (CMS)

Allison Burdick, Sr. (CMS) — John B. Murphy (CMS)
Charles A. DeKovessey (DS) — John P. Pope (DS)

This committee shall consider all questions regarding the registration and certification of delegates. The chairman shall keep the Speaker of the House informed of the voting power thereof.

The committee shall distribute and receive the attendance slips and perform such other duties as may be assigned by the Speaker.

This committee shall meet at least one hour prior to the opening session of the House on Sunday and one-half hour prior to the opening of the other two sessions.

Standby:
Robert E. Lee (CMS) — Burton Soboroff (CMS)

COMMITTEE ON RULES & ORDER OF BUSINESS

Karl Deterding, *Chairman* (DS)

Roland R. Cross (CMS) — Robert R. Mustell (CMS)
A. J. Kiessel (DS) — A. L. Robinson (DS)

This committee shall consider all matters regarding rules governing actions, methods and procedure, and the order of business (agenda) for the session of the House of Delegates. It shall work in close cooperation with the Speaker and Vice Speaker.

The committee shall contact the Speaker just prior to each session of the House to make sure that all recommendations for House action are included in its report.

Standby:
Vincent C. Freda (CMS) — Alfred Klinger (CMS)
Roger Fuller (DS)

TELLERS AND SERGEANTS AT ARMS

Anna Marcus, *Chairman* (CMS)

David W. Cromer (CMS) — Barry Seng (DS)
John L. Savage (CMS) — George Wilkens (DS)

This committee shall serve the Speaker of the House of Delegates whenever a vote count is called for, whenever a ballot is scheduled, or the House goes into executive session.

Standby:
Anthony G. Cesare (CMS) — Paul Lorenz (DS)
Frank Saletta (CMS)

REFERENCE COMMITTEE ON GOVERNMENTAL AFFAIRS & MEDICAL-LEGAL

William O. Ackley, *Chairman* (CMS)

Ross Hutchison (DS) — Charles A. Ramey (DS)
Frank Kwinn (CMS) — C. O. Smith (CMS)

This committee shall consider and submit its recommendations to the House of Delegates upon the following reports:

- Committee on Certificate of Need Legislation
- Special Project Committee with the Department of Mental Health
- Medical-Legal Council
- Governmental Affairs Council

Standby:
H. Frank Holman (DS) — Nathan A. Pitaro (CMS)
Donald H. Wrork (DS)

REFERENCE COMMITTEE ON ECONOMICS, PEER REVIEW, SOCIAL & MEDICAL SERVICES

Joseph B. Moles, *Chairman,* (CMS)

Crile Doscher (DS) — John Ovitz (DS)
William A. Hutchison (CMS) — Fred A. Tworoger (CMS)

This committee shall consider and submit its recommendations to the House of Delegates upon the following reports:

- Committee on Drugs & Therapeutics
- Committee on Hospital Manpower
- Council on Economics & Peer Review
- Council on Social & Medical Services
- Illinois Foundation for Medical Care
- Government Health Programs Reimbursement Committee

Standby:
William E. Erkonen (DS) — Clifton Reeder (CMS)
A. B. Johnson (DS)

REFERENCE COMMITTEE ON EDUCATION AND MANPOWER

Ralph G. Ryan, *Chairman* (DS)

William W. Curtis (DS) Henrietta Herbolsheimer (CMS)
Eugene Pitts (DS) J. Robert Thompson (CMS)

This committee shall consider and submit its recommendations to the House of Delegates upon the following reports:

Council on Education and Manpower
Illinois Council on Continuing Medical Education
Student Loan Fund

Standby:

Donald Edwards (DS) Kermit Mehlinger (CMS)
Loren B. Horton (CMS) Charles G. White (DS)

REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION & BYLAWS

Howard Burkhead, *Chairman* (CMS)

V. B. Adams (DS) Wayne Leimbach (DS)
Lawrence Hirsch (CMS) Raymond Nemecek (CMS)

This committee shall consider and report to the House of Delegates its recommendations on all proposed amendments to the Constitution and Bylaws.

Standby:

Arthur T. Haebich (CMS) William C. Perkins (DS)

REFERENCE COMMITTEE ON ENVIRONMENTAL, COMMUNITY & PUBLIC MENTAL HEALTH

John Hipskind *Chairman* (DS)

David Helberg (DS) A. Everett Joslyn (CMS)
Joseph Skom (CMS) James Reid (DS)

This committee shall consider and submit its recommendations to the House of Delegates upon the following reports:

Council on Environmental & Community Health
Maternal Welfare Committee
Council on Mental Health & Addiction
Director, Illinois Department of Public Health
Director, Illinois Department of Mental Health
Director, Illinois Department of Public Aid
Director, Illinois Department of Children & Family Services
Director, Illinois Division of Vocational Rehabilitation

Standby:

Herschel L. Browns (CMS) Charles O. Sandburg (CMS)
David Hegg (DS)

REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND ADMINISTRATION

Roland Kowal, *Chairman* (CMS)

Loren Boon (DS) Arne E. Schairer (CMS)
Stanley E. Ruzich (CMS) Alan M. Taylor (DS)

This committee shall consider and submit its recommendations to the House of Delegates upon the following reports:

President
President-elect
1st Vice President
2nd Vice President
Secretary
Chairman of the Board
Trustees from the 11 districts
Trustee-at-large
Speaker of the House
Vice Speaker of the House
Chairman, AMA Delegation
Executive Administrator
President, Woman's Auxiliary

Planning & Priorities Committee
Executive Committee
Policy Committee
Advisory Committee to Woman's Auxiliary
Ethical Relations Committee
Committee on Committees

Standby:

Harold Kolb (DS) S. W. Moore (DS)
E. J. Kotanyi (CMS)

REFERENCE COMMITTEE ON FINANCES, BUDGETS AND PUBLICATIONS

James A. McDonald, *Chairman* (DS)

Joseph R. DeCaro (CMS) Guy Pandola (DS)
Russell M. Jensen (DS) Louis A. Wajay (CMS)

This committee shall consider and submit its recommendations to the House of Delegates upon the following reports:

Educational & Scientific Foundation
Finance and Medical Benevolence Committee
Publications Committee
Treasurer
Budgets prepared and approved by Board of Trustees

Standby:

Allen Hrejsa (CMS) James Sutherland (DS)

REFERENCE COMMITTEE ON PUBLIC RELATIONS, MEMBERSHIP AND MISCELLANEOUS BUSINESS

E. T. Leonard, *Chairman* (DS)

Morris T. Friedell (CMS) Boyd McCracken (DS)
Julius E. Ginsberg (CMS) James C. Parsons (DS)

This committee shall consider and submit its recommendations to the House of Delegates upon the reports of the following committees and upon any other matters referred by the Speaker:

Insurance Committee
Council on Public Relations & Membership Services
Annual Meeting Joint Management Committee

Standby:

Julian Buser (DS) Nelson A. Wright, (DS)
Mathew W. Koback (CMS) Charles Mrazek (CMS)

Officers and Administration

President

My year as president of the Illinois State Medical Society is rapidly drawing to a close. In many respects, it's been a long, hectic and challenging year, but at the same time I must admit, it's gone by too quickly.

During one short year, medicine has undergone numerous changes—changes ranging from increasing government control in the form of PSROs, fee-freezes and proposed re-licensure exams to programs where the government and medical organizations are beginning to work together to alleviate problems, such as hospital overutilization and drug abuse. Our Hospital Admissions and Surveillance Program and the Illinois Drug Abuse Council, two such programs, just might produce some answers to these two growing problems.

As president of our state medical society, my goal has been two-fold. One, reach you, my fellow colleagues. Two, reach the lay public. My message to both was a plea for involvement. Or, stated more succintly, a plea for INDIVIDUAL RESPONSIBILITY.

One of the primary avenues for disseminating this message was the President's Tour. Each stop included an address before the county medical society and a local civic group, a district meeting with area medical society leaders and interviews with the local media.

As your spokesman, I addressed more than 2,500 physicians and lay people during stops in St. Clair, DuPage, Rock Island, Kane, LaSalle, Adams, Saline-Pope-Hardin, Southern Cook, Vermilion, Sangamon, Stephenson and Jackson counties. The publicity generated by over 40 radio and television interviews and coverage from approximately 50 newspapers helped carry our message to thousands more.

Along with his other duties, a president also inherits the duty of Ambassador to other states and medical organizations. I attended the Philippine Medical Association's Annual Meeting Sept. 9; the AMA Congress on Occupational Health Sept. 11; American Medical Political Action Committee meeting in Las Vegas Sept. 15-17; Illinois Newsbroadcasters Association meeting Oct. 1; AMA Conference on Air Pollution Oct. 2; Illinois Hospital Association meeting Oct. 25-26; AMA Meetings in San Francisco and Cincinnati; and the annual meetings of the Indiana, Ohio, Michigan, Missouri, Wisconsin and Iowa medical associations.

I felt the meeting with the Illinois Newsbroadcasters Association was especially rewarding. My message to them was also one of responsibility—the responsibility of the media to utilize their right of editorial comment. During our interchange of ideas, I learned of their capabilities and limitations and they, in turn, saw the health care picture from a physician's position. Basically, we began to communicate, which is the first step towards understanding two completely different worlds.

During the President's Tour, through my regular "President's Page" in the *Illinois Medical Journal* and at other meetings, I pointed out many problems that exist at the local, state and national level, both in government and organized medicine. But I also offered some possible solutions to these problems. Involvement and planning at the grass roots level . . . more comprehensive health education . . . preventive medicine . . . here are some problem solving tools within everyone's reach, consumers and providers.

The Illinois Foundation for Medical Care and its HASP program have occupied much of my time this year. Still relatively new acronyms to organized medicine, we have not yet begun to realize their potential. I believe it will be innovative approaches such as these that will allow physicians to retain their leadership role in our health care delivery system. But that will happen only if we make it happen.

Talking among ourselves and exchanging ideas and opinions is a good beginning; but it is only that . . . a beginning. We need to talk to the public too! If you're dissatisfied with government's action, tell them about it. Talk to your legislators, write to the key officials. Talk to your patients and friends. Give them the real facts concerning our health care delivery system. Only action begets action!

When I took office last March, I contended that one of our basic problems stemmed from the fact that the people of Illinois simply weren't informed. They didn't know what was happening in our health care delivery system. This year has proved that statement true.

ISMS went to the public for help when we were working to defeat House Bill 2033 (mandatory eye examinations for school children given only by an opthalmologist or optometrist). We gave the the facts and the information from Springfield, and we certainly got action. They wanted to help and they certainly did! This untapped potential lies in every community; let's start using it.

If we can do this, we will be providing the leadership and the tools needed to solve the problems of our health care system. We will be molding our own medical future. But we physicians will not succeed if we try to go it alone.

And that gentlemen, has been my message, my goal as your president. Yes, its been a tedious and challenging year; but, it's also been a year of goals and accomplishments with much hard work and many memorable times.

To the Board of Trustees, ISMS officers and staff, and to all my colleagues who have done so much . . . I say "Thank You and May God Bless You All."

Frank J. Jirka, Jr.

PRESIDENT ELECT

In addition to assisting our distinguished, dedicated, hard working President, Dr. Frank Jirka, Jr., whenever requested, the following are dates of events and activities attended:

March 23: Washington County Medical Society meeting honoring Dr. Longwell.

April 6-8: AMA 6th Clinical Congress, Ft. Lauderdale, Fla. I presented a paper on IFMC, HMO, HASP.

May 6: Journalism awards dinner. The Globe-Democrat, St. Louis, Missouri, was presented with an award. This is the first newspaper so honored outside of Illinois.

May 17: Participated in program on WIBV, radio station, in Belleville, on health and medical care, Medicare, insurance programs, aims of ISMS; with a question and answer period following.

May 20: Attended Lincoln Academy of Illinois convocation and investiture of members, Springfield; including Governor Ogilvie's reception and all formalities including banquet. Visited with Mr. McCarter, Bureau of Budget; Mr. Daley; and renewed acquaintance with Ex-Governor Kerner and Ex-Governor Stratton.

June 1: Attended Illinois Hospital Advisory Commission meeting, Springfield. Represented Dr. Jirka at State Senate Welfare Committee hearing.

June 1: Presented Dr. Matthew Eisele with a public relations award from St. Clair County Medical Society.

June 18-19: Attended subcommittee on health care delivery of American College OB-GYN, San Francsico.

June 17-21: Attended AMA Convention, San Francisco.

August 1: In attendance at the officers meeting with Candidate for Governor, Dan Walker.

August 6: Attended Governmental Affairs Committee and IMPAC at which candidate support and related matters and innovations, governmental affairs were discussed.

August 8: Meeting with consulting firm engaged by ARCH to study feasibility of extent of involvement by Comprehensive Health Planning of Illinois and Bi-State ARCH. Views of Illinois physicians and citizens of areas involved were presented.

August 16: Strategic committee meeting with Governor Ogilvie in Chicago. Bills for public aid, medical liability and related matters of importance discussed. Results to be announced.

August 25-26: Attended AMA Committee Health Care of the Poor meeting in Chicago.

September 10: Comprehensive State Health Planning Agency annual meeting was held in Joliet.

September 21: Attended testimonial ceremony for Clyde Shoate, Springfield.

September 23-24: Central states medical group meeting, Indianapolis, Ind., with Dr. Hess, Kentucky; Dr. Petrich Ind.; Dr. Adler, Mich.; and two doctors from Wis. An arrangement for loose structure; a need for meeting to discuss problems of mutual interest and exchange of ideas was accomplished. The latent possibility of some political significance was not spelled out.

October 4: Represented Dr. Jirka at annual meeting Illinois Nursing Home Association, Springfield. Most pleasant experience due to solicitous hosting by Mr. Melvin Moehle, their legal counsel, and Mr. Ross Reardon, executive director. On the occasion had constructive discussions with the lobbyist of Illinois Nurse Association, Mr. Weaver, and Dr. Flashner.

October 10: Attended Republican dinner in Belleville. Met with Secretary Elliot Richardson of HEW and learned that he personally favors Foundations participating in experimental HMOs; he expects no major developments in this area the rest of this year. He strongly embraces the cooperative efforts of organized medicine in matters of mutual interest.

October 26-28: Washington, D.C., Committee Health Care of the Poor. Interviewed with HUD, Model Cities, and OEO. Personal interview with Mr. Reubel on PSRO.

November 9: Southern Illinois Medical Society meeting, Belleville. It was a combined 9th and 10th district meeting.

November 24-29: Attended AMA Clinical Conference, attended president and president-elect session on problems of mutual interest to state presidents and presidents-elect and PSRO Forum.

December 7: Attended inaugural meeting of ISMS Committee on Health Care of the Poor and Committee on Governmental Payments with Mr. Bob Wessel present.

December 12: Advisory Committee meeting to State Comprehensive Health Planning Council, Springfield.

December 14: Along with other officers, I visited HEW and other governmental offices, Washington, D.C. for ISMS on PSRO.

Attended all scheduled board meetings and others expected of the office. Mr. Roger N. White and the ISMS staff have assisted greatly in making suitable arrangements and contacts for these assignments.

W. C. Scrivner

First Vice-President

As the first vice-president I have been privileged to attend the meetings of the Board of Trustees and participate in its deliberations.

During the year I have represented the interests of the medical community in dealing with several agencies active in the field of drug abuse prevention.

Joseph Skom

Second Vice-President

Report not received at time of publication.

Secretary-Treasurer

The report of the Secretary-Treasurer will be found under Finances and Budgets, page 146.

TRUSTEES

First District

Sometimes called the "shore to shore district" because it extends from Lake Michigan to the Mississippi River, the First District encompasses the full spectrum of medical thought and achievement.

This was brought into focus by the well conceived resolutions presented by its component county societies, of which all received careful consideration by reference committees and some of which became the foundation for inclusion in the Policy Manual.

Forward-looking leadership was, and is, exhibited by their vigorous support of, and participation in, foundation activities. The delegates and county society officers have served as effective liaison between ISMS and the members.

At an interim district meeting held in DeKalb on November 18, 1972, it was apparent that the county society components continue to stand ready to translate constructive criticism into affirmative action for the betterment of patient care.

The coming year promises to bring many health plans and concepts to the attention of organized medicine. Our success in meeting the needs of the public and our patients depends on the degree of unity we can achieve. Your Trustee is confident that the First District will contribute its many talents toward this end.

J. L. Bordenave

Second District

During my second year as trustee, I have become amazed at the casual, determined manner of the social planners and politicians who are blue printing the future of medicine, including total institutional type care and hardly acknowledging the existence of private practice fee-for-service type care. Dr. Frank J. Jirka, Jr., and the leadership of the ISMS have spoken clearly of the need for physicians in private practice to take the time to become involved; to keep themselves informed of pending legislation; to voice their opinions to the leadership of the ISMS; to help educate their patients as to the potential results of the current trends toward government control of medicine; to make their views known to their legislative representatives; and to participate in ISMS to help establish policy and aid in its implementation. My goal for the coming year is to help inform the membership of proposed changes and seek their support in helping maintain a rational system of medical care delivery.

Allan L. Goslin

Third District

Report not received at time of publication.

Fourth District

The President's Tour came to Rock Island County in the IV District, which offered an excellent opportunity for the Delegates of the district to meet with the ISMS President, officers and staff members. Several matters of interest to our members were discussed and subsequently brought to the attention of the Board of Trustees. Since several counties in this and other districts were attempting to establish funded health departments, the Board was asked to endorse these efforts through reaffirmation of our policy supporting local health departments. The ISMS Board of Trustees also responded favorably to a request from Rock Island County for full distribution of Action Report.

There has been much discussion through the district on Foundations and HASP, and I hope that a better understanding of both now exists. The newest demon to raise its head is PSRO; several meetings will be held in early 1973 throughout this district in an attempt to bring illumination to this dimly perceived concept.

In attempting to represent the IV District, I have attended all Board meetings, and as many meetings of Board committees, membership committees and task forces as time and conflicting schedules would allow.

I am particularly thankful for the concern and interest of the delegates and members of this district, and am deeply appreciative of the willingness and ability of our County Execs and of ISMS staff to put out that extra effort—to walk that extra mile.

Fred Z. White

Fifth District

The past year was one of quiet change. By this is meant the infiltration of medical education into the clinical practice of medicine in the Fifth District. For the most part there was little friction and most of the local practitioners of medicine have accepted the situation and have sought to help in the establishment of the schools. This has not been and is not easy as there have been certain compromises to make. By and large, however, most of the basic difficulties have been ironed out and now the way seems clear to establishing a very good rapport between the full-time staff and the part-time clinicians who have volunteered their assistance. The future looks very promising. This applies not only to the Springfield school sponsored by Southern Illinois University, but also to the Champaign-Urbana School of Basic Sciences which is utilizing hospitals not only in the Champaign-Urbana area, but also in Decatur and Bloomington.

There have been numerous attempts by small towns to obtain practicing physicians in the 5th district area. To date only moderate success has been achieved. It has been thought, however, that some utilization of suitably trained nurses could very well be substituted for doctors of medicine. Discussions are being held with the smaller towns concerning this matter but to date no action has been taken.

A. E. Livingston

Sixth District

A meeting of the Sixth District delegates will be held in late March, 1973, in Chicago, immediately before the Annual Meeting of the Illinois State Medical Society; all delegates from the Sixth District are urged to attend. The Sixth District was honored to have Frank J. Jirka, Jr., ISMS president, visit Alton in June, and Quincy in October. He was well received by the members in both communities.

In 1972, no problems have arisen in the Sixth District which required the attention of the various District Committees.

The HASP program seems to be functioning fairly smoothly in our area of the state. Dissatisfaction with IDPA fee allowances and anger over the return of report forms for petty and trivial "corrections" is widespread. At times it appears to be almost planned harassment by the employees of the Department of Public Aid. The promised simplified report form is eagerly awaited.

I have attended most of the meetings of the Board of Trustees during the past year, as well as most of the meeting of the committees on which I serve. Once more I must express my admiration for the dedicated work of the ISMS staff members in Chicago and Springfield. I find them most willing and helpful whenever they are called upon.

Mather Pfeiffenberger

Seventh District

District Committees on Ethical Relations, Grievance and Prepayment Plans had no call for meetings during the year. There have been no reports of any further organization of Health Maintenance Organization in the Seventh District since last year.

Members of the Societies in the Seventh District have shown interest in the Illinois Foundation for Medical Care, approval coming from the Macon County Medical Society recently. Hospital Administration and Surveillance Program (HASP) is functioning satisfactorily.

Your Trustee feels that the meeting held by the Board of Trustees in October of 1972, at which all component Societies of the Seventh District, Executives and Delegates were invited to attend, was one of the most fruitful type of meetings ever held. The chance for various Societies to ventilate over many problems relative to Medicare, Medcaid and HASP proved most beneficial and instructive.

This is the "Swan Song" of your Trustee. He has served on the Illinois State Medical Society Board of Trustees 21 years. In other words it is time for a change. It has been a very gratifying experience and the opportunity is taken now to thank the component Societies and Womans Auxiliary for their wonderful cooperation and support during the years of service.

Arthur F. Goodyear

Eighth District

The Eighth District has been represented at all meetings of the Board with the exception of the first day of the May, 1972, meeting. It has been the intent of your Trustee to voice the feelings of all county medical societies in our area, as well as to act for the benefit of all Illinois physicians and their patients. It has not been possible to meet with all county societies in the district; phone contract and liaison has been established with all, especially with delegates and alternates.

Because of my duties on the IFMC Executive Committee. serving as a member of the State HASP Committee, participating on various ISMS committees, and the required extra attention on the part of all Trustees and other informed physicians occasioned by the rapid threatening developments in governmental health programs, I must honestly admit that not as much was done at the local level as I would have desired.

Eugene Johnson

Ninth District

Since this is my first year to serve as your Trustee, I have attempted to familiarize myself with the procedures and activities of the district and the ISMS.

The Ninth District Grievance and Peer Review Committee met once during the past year to hear one dispute and I attended this meeting. I have attended all of the Board of Trustees meetings throughout the past year and the meeting of the Southern Illinois Medical Society of which the Ninth District Trustee is a member of the Board of Directors.

Our District was honored by having Dr. Frank Jirka, Jr., ISMS President, visit us on Novmber 13, 1972, at the Saline-Pope-Hardin Medical Society meeting. A "feedback session" was held at that time for all District Delegates and County Medical Society officers.

The majority of the Ninth District Delegates approved of my suggestion that we plan to meet quarterly following the meetings of the ISMS Board of Trustees.

It has been my pleasure to serve as your Trustee.

Warren D. Tuttle

Tenth District

My first year as Tenth District Trustee has been one of indoctrination, learning and a period of formulating goals for the remainder of my term.

In visiting with the members of the Tenth District the three main points of discussion are: 1. HASP; 2. Usual, Customary and Reasonable plan of re-imbursement in the care of Medicaid patients; and, 3. Medicare.

It is generally agreed that the released figures of HASP prove, statistically, the job is being done. The question so often raised is "Is this good for the future practice of medicine?" This, too, needs closer surveillance.

The Usual, Customary and Reasonable fee basis in the Medicaid patient re-imbursement plan, at least, leaves much to be desired. Since ISMS approved this plan in 1966, we feel that perhaps ISMS should reverse its stand and a new approach should be studied and undertaken.

Medicare is operating as most of our physicians felt it would. We seem to be unable to do anything about this except to accept it.

Finally, my attendance at the Nutrition Program at SIU, Carbondale, was enlightening. It was well attended by every one except MD's who were conspicuous by their absence. We wonder whether the ISMS should continue to co-sponsor this program.

Herbert P. Dexheimer

Eleventh District

As trustee, I attended all the scheduled Board meetings during the past year, as well as acting as an advisor to the Council on Medical Economics and Peer Review. I also served as Chairman of a reappointed committee on Governmental Health Program Reimbursement, whose principal function to date has been to discuss procedural problems with the Illinois Public Aid. In these rapidly changing times effort has been expended in following the progress of federal legislation with respect to PSRO, and HMO's. The problem of communicating to the constituent medical societies information regarding legislation is becoming very acute. It is most urgent that everyone be totally aware of all the implications involved in these legislations and I sincerely urge everyone to attend the informative meetings being planned by ISMS on these subjects.

I realize fully that everyone's time is most important and priorities must be set in order to best utilize one's free time away from a busy practice; perhaps the one solution is to reinstitute the meetings of the officers and delegates of each local medical society on an on-going-basis, quarterly or more often as the need arises.

It is my privilege also to serve as president of the Illinois Foundation for Medical Care, a job which entailed many meetings both in Chicago and throughout the state.

I also attended all the sessions (clinical and annual) of the AMA as an alternate delegate, and have recently been appointed to the AMA Ad Hoc Committee to Study PSRO Legislation.

Joseph R. O'Donnell

Trustee-at-Large

The constantly accelerating involvement of the affairs of medicine with politics and legislation is placing an increasing strain upon the time and talents of all of the trustees and officers of the Illinois State Medical Society. New laison, ad hoc and advisory committees spring up like red Morrel mushrooms in April. The seas have been so rough that an inordinate amount of time is being devoted to keeping the ship afloat and on course, and not enough time is being spent studying who is going to do what, to whom once the ship arrives at its destination. The following tornadic vortices have been inspected from the inside:

1. Legislative activity in Washington and Springfield.
2. Pet projects of the Illinois Code departments, specifically (A) Medicredit, (B) Regional Trauma Center, and (C) Mental Health.
3. Comprehensive Health Planning, specifically Region V and Sub-Region IV of Region V.
4. The Foundation for Medical Care and HASP.
5. The hectic pace of the executive committee and the Board of Trustees of the Illinois State Medical Society.

It is a prerogative of the Trustee-at-Large to peer dimly ahead through the fog and guess where the icebergs are.

1. There is a great likelihood of passage of some type of national health insurance which will again effectively increase demand for primary medical care without doing anything to increase the available supply.

2. There is a strong possibility of some type of legislation on the state and/or national level which will destroy our local ambulance services, disrupt patterns of referral and patient care, and result in a lower quality of care available to the rural residents of the state.

3. There will be increasing harassment of the privately practicing physician both directly through increasingly strict requirements for recertification, relicensure, and continuing education, and indirectly through constriction of his option to prescribe via rules and regulations of the FDA and of third parties.

4. After the American physician has agreed that he has had "enough," I look for one of two things to happen—either the AMA will move in the direction of a union with a popularly elected president, who will stand for re-election by popular vote of the membership every four years; or I look for a degeneration of the AMA into a scientific assembly with its main interest in the areas of research, education, and quality standards accompanied by the rise of a national union of doctors prepared to use coordinated measures to protect what they believe to be their vital interests. Most AMA members at the present time are marking time waiting to see if our toothless leadership can locate the Poli-grip.

5. The medical schools and hospitals with residency training will come face to face with reality and start producing the kinds, quantities, and types of doctors the public wants and needs. They will be "encouraged" in this direction by federal grant strings.

C. J. Jannings, III

CHAIRMAN OF THE BOARD OF TRUSTEES

During the past year, your chairman endeavored to implement the House of Delegates directives as effectively and efficiently as possible and make ISMS a more potent force in the state's legislative and socio-economic circles.

I am pleased to report that all directives of the 1972 House have been, or are in process of being implemented. Among those was the restructuring of our councils, which called for the abolishment of all committees working under them. Those committees that were recreated upon request of the councils were appointed on an ad hoc basis only.

Developments:

Following are some of the more significant developments resulting from Board of Trustees actions during the past year:

1. Improved membership communications by replacing the society's monthly publication, "Pulse", was a timely bi-monthly newsletter called "Action Report," devoted primarily to socio-economic and political news of interest to Illinois physicians.

2. Increased ISMS membership to an all-time high of 11,100 physicians (as of January 15, 1973).

3. Authorized a six-month study of the medical malpractice problem in Illinois; the results will be published in the *Illinois Medical Journal.*

4. Endorsed the concept of arbitration as a partial solution to the professional liability problem and authorized development of a pilot project in Illinois.

5. Offered members a new, improved liability insurance program. Effective June 1, 1973, ISMS members will have an opportunity to enroll in the society-sponsored plan underwritten by the Hartford Insurance Company and administered by Johnson-Higgins Insurance brokers.

6. Initiated a new, society-sponsored business overhead insurance program for ISMS members.

7. Co-sponsored a membership retention drive with the Chicago Medical Society and the American Medical Association, promoting the benefits of unified membership. This was done through distribution of a membership brochure with the 1973 dues statement.

8. Obtained the assistance of Governor Ogilvie in securing a new, simplified billing form for physicians providing services to public aid recipients. The form, slated to be available in March, is expected to streamline the physician's work and guarantee more prompt payment.

9. Sponsored a Leadership Conference on Malpractice and Arbitration which attracted more than 300 physicians, lawyers and hospital personnel.

10. Developed a position paper on health care licensure. The paper, which contained some 14 recommendations, was presented to the Illinois Health Care Licensure Commission which, in turn, will make its recommendations to the General Assembly.

11. Sponsored the second annual Doctor's Job Fair, which attracted some 400 representatives of 65 communities and over 200 job seeking physicians. The program, which helped 12 communities obtain physicians in 1971, received nationwide publicity.

12. Assumed the administrative responsibilities of the Illinois Psychiatric Association, Illinois Association of Ophthalmology, and the Illinois Society for Internal

Medicine. Administrative services are provided to them at cost, with the organizations sharing expenses of a secretary officed in the ISMS headquarters.

13. Developed a "Statement of Understanding" for use by the membership in their relations with patients covered by Aetna Insurance and other firms distributing "hold harmless" letters to their policy holders. Over 25,000 copies of the form were distributed.

14. Implemented House of Delegates directive to foster medical careers among minority groups by providing $9,000 grants to both the Council on Bio-Medical Careers and ASPIRA, Inc.

15. Provided over 1,000 ISMS members and their families with outstanding travel seminars to the Far East, Scandinavia and Europe at a substantial saving. The Society sponsored six of these trips since the last annual meeting.

16. Encouraged all county and branch society presidents in the fifth and third districts to participate in an "Open Forum" at our October and January Board meetings. The sessions provided local leaders an opportunity to address the board directly on any issue they chose.

Recommendations for future:

1. Educate ISMS members on the effect PSRO will have on the practice of medicine and provide leadership in the development of PSROs throughout the state.

2. Resume the society's $10-per-member allocation of AMA-ERF contributions to the Illinois Council for Continuing Medical Education for 1974; and to provide ICCME with as much assistance as necessary to help it become a viable organization.

3. Make the society a more effective force in the AMA House of Delegates by better utilizing the knowledge and experience of ISMS officers, trustees, council and committee chairmen.

4. Assume a more aggressive role in seeking appointments to the AMA Board of Trustees, councils and committees. While ISMS is the fourth largest state medical society in the country, it is conspicuous by its absence on many of these bodies.

5. Continue the practice of "Open Forums" at all Downstate meetings and at least one Chicago meeting of the Board of Trustees each year. They are extremely valuable in providing the board with an insight into the concerns of county and branch societies.

6. Continue assistance to the ISMS Woman's Auxiliary and the American Association of Medical Assistants, Illinois chapter.

William M. Lees

SPEAKER OF THE HOUSE

The duties as speaker have been a repeat of the previous years and, though the challenges of the office remain, I feel that three continuous years have been too long. At my suggestion, the Constitution and Bylaws Committee has prepared changes in the By-Laws to limit the consecutive years in the office to two. Two years as vice speaker and two as speaker are enough for the membership and the member.

The more notable aspects of my year have been serving on the Board of Trustees as liaison to the State of Illinois Trauma Program; as ex-officio or consultant member of the Executive Committee, Constitution and ByLaws Committee and Council on Social and Medical Services; as a director of IFMC; and as alternate Delegate to the AMA. It is obvious that a responsive and dedicated staff is necessary to carry out the policies established by us in the position of leadership, if we are to maintain our contact with medical reality by practicing medicine.

It is my personal feeling that we are spending too much time and effort on economic, social and education problems that obliquely or indirectly affect medicine. For example, we are being given financial incentives to certify that services are medically necessary; that the quality is of recognized standard; and that the service is provided for in the least expensive setting, rather than giving the financial incentive to the recipient of our services!

We should spend more time on assisting and motivating our profession in professional excellence through continuing medical education (we have a beginning); more effort in increasing the accessibility of health care (publicize the maldistribution of physicians); a monumental campaign, from adolescent motivation to physician retirement to remind us that our professional effectiveness is related to our degree of responsible and ethical service to mankind.

This brief overview results from the privilege you have afforded me as your Speaker of the House for the past three years.

Paul W. Sunderland

VICE SPEAKER OF THE HOUSE

There is no report at this time.

Andrew J. Brislen

EXECUTIVE ADMINISTRATOR

The resolutions and other directives adopted by the 1972 House of Delegates have been fulfilled to the best of our ability. Several matters, referred for study, will be reported back.

As of January 1, the staff complement was increased by one additional full-time employee, a clerk-typist in the Governmental Affairs Division, to assist in handling an ever-burgeoning legislative load. During the year the full-time position of Advertising Manager of the *Illinois Medical Journal* was eliminated as well as the part-time position of New York sales representative for Journal advertising. These functions are currently being performed by United Media Associates, Inc., a national agency specializing in the sale of advertising in state medical journals. We look forward to increased *Journal* advertising revenue at a lesser net cost to the society. The one full-time position saved by this move has been allocated to the Division of Health Care Delivery where additional staffing is indicated.

The year ended in deficit as budgeted. A portion of the funds generated by the dues increase, effective in 1973, must be utilized to erase this deficit. A plan for setting aside reserves has been developed in conjunction with the Finance Committee to assure the membership that no further increase in dues will be sought for five years, except under highly unusual circumstances. Delegates should be aware that priorities are constantly bieng applied to all avenues of expenditure. In October, the Board of Trustees voted approval of the employment of up to three additional field staff to assist the individual Trustees in furthering their work in the District. However, in developing the 1973 budget no clear pathway was available for adding that many additional employees within the confines of the five-year dues plan. This situation will be evaluated over the next six months to ascertain the priorities involved in such a move as compared with other needs.

During the first half of 1972 much dialogue took place in Washington concerning new directions in health care delivery. Department of HEW grants for over 100 HMO experiments and Congressional activity on HMO subsidy bills seemed to indicate a serious effort by government to challenge the fee-for-service system. By year-end this direction had altered materially. The HMO option, written into the Medicare and Medicaid programs, failed to include the financial incentives needed to generate large-scale HMO development. Congress, with administration support, passed legislation to permit groups of physicians to establish Professional Standards Review Organizations (PSRO's), a move designed to strengthen the effectiveness of the fee-for-servie system. Assuming an affirmative response to PSRO by the House of Delegates, much of the Society's resources will likely be expended in this direction during the coming year. Some of the ground work for PSRO has been done in the Hospital Admission and Surveillance Program (HASP) under the Foundation for Medical Care.

At this writing, little is known of the direction health programming may take under the new administration in Springfield. A continuation of the trend in the General Assembly toward an increase in the number of health related bills is anticipated. Several significant recommendations affecting licensure are anticipated when the Health Care Licensure Commission reports to the General Assembly in March.

To remain viable, the Society must remain on top of each new development as it occurs. It is a prime responsibility of staff to keep abreast of these matters and see that the Society's leaders are properly alerted. I am proud to commend to you a dedicated staff, capable of performing in this fashion. Frequently they are called upon to exceed the level of performance normally expected in their job routine. In each instance the response has been gratifying.

Appreciation is also expressed to members of the Board of Trustees, Auxiliary members and the many other Society leaders for their assistance. No staff could wish for a more dedicated group of people with whom to work. The day-to-day Society activity places your Executive Administrator in frequent contact with the top officers, often at great inconvenience to themselves and their work schedules. Their willingness to respond and contribute to the work of the Society has been most magnificent.

Roger N. White
Executive Administrator

DELEGATION TO THE AMA

The Illinois Delegation to the American Medical Association met during the 1972 ISMS annual meeting in Chicago in addition to its daily meetings during the June and November sessions of the AMA House of Delegates.

In the interest of economy, the traditional luncheon given for all AMA delegates and alternates was eliminated in 1972. However, the Illinois delegation maintained a hospitality suite during the annual meeting in San Francisco and the clinical convention in Cincinnati for the purpose of becoming acquainted with members of other delegations.

At both AMA meetings, every delegate and alternate was made responsible for studying a specific section of the Delegates Handbook and reporting his recommendations on the reports and resolutions appearing in that section. The same member was also responsible for attending the reference committee where these reports and resolutions were discussed so that he could report back to the delegation on the testimony presented at the reference committee hearings.

At the June meeting in San Francisco, Dr. Edward Piszczek served as a member of Reference Committee A (Insurance and Medical Service); Dr. Theodore Grevas on Reference Committee F (Board of Trustees), and Dr. Philip G. Thomsen as a member of the Credentials Committee.

At the Clinical Convention in Cincinnati, Dr. H. Close Hesseltine served as Chief Teller; Dr. Jack Gibbs as a member of Reference Committee A, and Dr. Harold Sofield as chairman of Reference Committee E (Scientific-Public Health).

Illinois introduced six resolutions at each session of the House of Delegates.

In June, **Resolution 1**, which discouraged smoking during sessions of the House of Delegates, was adopted.

No. 59, asking that the help of President Nixon and the federal government be sought in alleviating the malpractice claim problem and encouraging national legislation that will provide alternatives to present professional liability laws, was referred to the Board of Trustees. The reference committee reported that the intent of the resolution was being carried out by the AMA presently assisting an HEW Commission on Medical Malpractice. The findings of this commission are now being awaited. In the meantime, the reference committee advised that state societies be encouraged to develop their own liability programs and seek appropriate legislative remedies for problems at the state level.

No. 60, asking the AMA to explore the possibility of court action to prevent government encroachment on physician rights; it was referred to the Board of Trustees for more informed review than was possible during reference committee hearings.

No. 61, requesting AMA endorsement of a new National Institute of Gerontology, was defeated after being opposed by the AMA Committee on Aging, which testified that existing National Institutes of Child Health and Human Development are providing adequate service.

No. 62, dealing with the educational problems of U.S. students trained in foreign medical schools, was referred to the Council on Medical Education.

No. 63 was one of a number of reports and resolutions dealing with training and certification in nuclear medicine. A substitute resolution, incorporating most of the various positions, was proposed by the reference committee and adopted by the House.

In November, a substitute was adopted for **Resolution 6**, which called the attention of the House of Delegates to the alarming increase in the incidence of venereal disease in the United States and directed the AMA to place special emphasis on health education programs and additional efforts to develop modifications in public attitudes and values in order to decrease the exposure to and incidence of gonorrhea.

The following substitute was adopted:

RESOLVED, That the American Medical Association continue to assert appropriate leadership in a concerted program to control venereal disease through intensified public education, the development of effective and adequate case finding, treatment and prompt reporting, and support of research dedicated to the development of vaccines to produce active immunity to venereal disease; and be it further

RESOLVED, That the American Medical Association continue to urge physicians to take all appropriate measures to reverse the rise in venereal disease and bring it under control with particular emphasis on the importance of prompt reportng and the provision of assistance to public health departments; and be it further

RESOLVED, That the American Medical Association encourage constituent and component societies to support and initiate efforts to gain public support for increased appropriations for public health departments to support research in the development of practical methods of prevention and detection of venereal disease with particular emphasis on the control of gonorrhea; and be it further

RESOLVED, That in those states where state consent laws have not been modified, that the constituent associations support enactment of statutes that permit physicians and their co-workers legally to treat and to search for venereal disease in minors without the necessity of obtaining parental consent; and be it further

RESOLVED, That the Board of Trustees report at the next Clinical Meeting of the nationwide incidence of venereal disease at that time and to make any additional recommendations for the control of the epidemic of venereal disease.

The following substitute was also adopted in lieu of **Resolution 7**, which requested that all state medical associations be urged to adopt unified membership, by which all of their members would be members of the American Medical Association:

RESOLVED, That all state medical associations should consider having all members support all levels of our national federation by adopting, where possible, the unified concept.

As a substitute for **Resolution 8**, which directed the AMA to encourage efforts to educate the public to the various aspects of the sickle cell problem and to encourage state, county and local health departments to promote sickle cell programs and disseminate informational materials for school health courses, particularly in areas with sizeable susceptible populations, the House adopted the following:

RESOLVED, That the American Medical Association continue to encourage research and educational efforts directed to the profession and the public pertaining to the sickle cell problem and encourage state, county and local health departments on a voluntary basis to disseminate information concerning the problem through health courses in all schools with susceptible populations; and be it further

RESOLVED, That the question of insurability of persons with sickle cell problems be referred to the Board of Trustees for further and intense study; and be it further

RESOLVED, That the American Medical Association continue to concern itself with the issues involved in genetic counseling; and be it further

RESOLVED, That the Board of Trustees report to the House of Delegates at the Annual Meeting in June of 1973 suggestions as to how the AMA might best study these issues and coordinate with other efforts being made in our society to deal with these issues; and be it further

RESOLVED, That the American Medical Association feels it is important that all sickle cell programs have input in the planning stage from the local black community and all other areas of the community that would be involved and affected by the sickle cell trait.

Resolution 9 directed the American Medical Association to encourage virologists to seek smallpox vaccine that will produce fewer adverse reactions and greater length of immunization and encourage physicians to continue immunizing patients against smallpox. The House amended this resolution to read as follows:

RESOLVED, That the American Medical Association encourage modern biological virologists to seek new methods of immunization against smallpox producing less reaction and greater length of immunization; and be it further

RESOLVED, That physicians, while observing contraindications, have the option of immunizing patients against smallpox, whether or not immunization is required by the U. S. Public Health Service or other countries.

Resolution 60, which directed the AMA to assume the leadership in developing Professional Standards Review Organizations, was presented to the House of Delegates with a Report of the Board of Trustees and Council on Medical Service, which was amended several times on the floor of the House before being adopted as follows:

Public Law 92-603 (HR 1), which enacted the **Professional Standards Review Program for Medicare and Medicaid programs,** was signed into law on October 30, 1972 .As yet, none of the details of the program, beyond what is contained in the language of the law itself, have been formalized; the process of writing the Federal regulations and of defining the boundaries of the areas in which Professional Standards Review Organizations (PSROs) will operate has not yet begun.

When this legislation was under consideration by the Congress, the American Medical Association questioned whether a government operated program of mandatory peer review geared in large part to cost control could be effective without reducing the quality of patient care.

Notwithstanding this concern, however, since PL 92-603 has been adopted, the Council on Medical Service and the Board of Trustees believe that the American Medical Association should provide a dominant role of leadership in the implementation of the PSRO program to assure that the best interests of the public and the profession are preserved.

The Board of Trustees and the Council on Medical Service therefore recommend that this House of Delegates authorize the Board of Trustees to create within the American Medical Association an Advisory Committee on Professional Standards Review, to include members from the Board of Trustees and the Council on Medical Service, and that the Board of Trustees be authorized to invite other appropriate organizations to participate in this Committee.

The Board of Trustees and the Council on Medical Service suggest that the initial assignment of this Advisory Committee include the following responsibilities:

1. To provide input from the medical profession in the development of the rules and regulations which will

govern the Professional Standards Review Program;

2. To assist state medical associations, or state medical associations in concert with county medical societies, in developing Professional Standards Review Organizations, and to recommend structures and operating mechanisms for such PSROs;

3. To aid in defining appropriate geographic boundaries for PSROs, especially in instances where more than one state may be involved;

4. To develop and transmit to PSROs recommended operational procedures;

5. To assure that the development of "norms of health care services" called for in the law in regard to medical necessity of care provided, length of stay, and appropriateness of the site of care shall have full input from the various medical specialties and the medical profession generally and shall recognize regional and local differences in patterns of medical care;

6. To identify sources of existing data and experience which can be used as a basis for developing such regional or local norms of health care services, as well as identifying those areas in which current data are insufficient for this purpose and need further development;

7. To utilize the data obtained from Professional Standards Review in the development and administration of voluntary continuing medical education programs;

8. To develop and maintain liaison with appropriate governmental agencies involved in the Professional Standards Review Program, as well as with other state, national and local groups and agencies which have developed expertise in these areas;

9. To develop and disseminate information about Public Law 92-603 as the basis for a constituent society developing an understanding of the law;

10. To continue to furnish to the Council on Legislation material that may be used for future bills embracing the type of peer review already approved by this House of Delegates;

11. That this Committee and other AMA councils and committees monitor the effect of PSRO on the quality of medical care and report their findings to each future meeting of this House of Delegates.

Report 2 of the Board of Trustees and Council on Medical Service, adopted as amended and in lieu of **Resolution 60,** reaffirms that the AMA is a strong advocate in support of the medical profession whenever regulations or administrative policy interfere with the practice of medicine and additionally requests that the Board of Trustees inform the House and state societies as to procedures to follow whenever the rules and regulations interpreting the law and published in the *Federal Register* seem to be contrary to the spirit of the law as written.

Resolutin 61, requesting that the AMA urge proper physician involvement in health components of Model Cities Program, was amended and adopted as follows:

RESOLVED, That the AMA urge the Model Cities Program, at all levels, to obtain adequate continuing advice and assistance from practicing physicians in the planning, operation and evaluation of health programs and that such physician involvement at the local level be a requirement for federal approval of local programs; and be it further

RESOLVED, That Model Cities administrators, at all levels, be informed of the willingness of physicians to cooperate in providing such medical advice and assistance on a continuing basis.

At the opening session of the House of Delegates in Cincinnati, Dr. Frank J. Jirka, Jr., ISMS President, presented to the AMA Research and Education Foundation a check for $90,000. It was announced that this check brings to $3,236,000 the amount contributed by Illinois doctors to AMA-ERF.

Attending this meeting as members of this delegation for the last time were Drs. Francis W. Young, Delegate and Joseph R. O'Donnell, Alternate Delegate. They were replaced January 1, by Dr. Theodore R. Van Dellen, who will become a delegate after serving as an alternate for several years; Dr. Alfred Faber, who takes Dr. Van Dellen's place as an alternate; and Dr. E. T. Leonard, who replaces Dr. O'Donnell.

At the final meeting of the delegation in Cincinnati, Dr. Carl E. Clark was elected delegation chairman to succeed Dr. H. Close Hesseltine, who held the post for the past two years. Dr. Edward A. Piszczek was elected secretary, replacing Dr. Clark in that position.

Carl E. Clark, *Chairman*
Edward A. Piszczek, *Secretary*

Highlights of the Annual Meeting

President's Night
March 27

Public Affairs Breakfast
March 27

Plan to Attend

Conference on Professional Standards
March 25

Committees of the Board of Trustees

ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY

The Committee met formally with the officers of the Woman's Auxiliary in January to discuss their program and problem areas. Informal assistance was rendered by the Committee on several other occasions throughout the year.

We wish to commend the Auxiliary for the high calibre of their program. In addition to several facets which appeal exclusively to the women, the Auxiliary plays a vital supporting role to ISMS in such areas as legislation, public affairs, public relations and financial support of the benevolence program. The Auxiliary has accepted an expanded role in the President's Night program at the Annual Meeting and have been helpful in planning the program.

Membership continues to be one of the Auxiliary's primary concerns. The total membersip stands at about 3,000 members, or less than one-third of that of the active dues paying ISMS members. Membership in Cook County is below 500 against a Medical Society membership of some 6,500. From time-to-time campaigns for membership are instigated. Joint membership dues billing between the Auxiliary and the Medical Society is available and to be encouraged. We urge all delegates and County Medical Society officers to lend support to their Auxiliary whenever possible.

The Advisory Committee wishes to express appreciation to Mrs. August Martinucci, Auxiliary President, her officers and the entire Auxiliary for their excellent support of the Illinois State Medical Society.

Willard C. Scrivner, *Chairman*

Frank J. Jirka — William M. Lees

CONSTITUTION AND BYLAWS

All amendments to the bylaws ordered by the 1972 House of Delegates were made in the copy of the Constitution and Bylaws published in the October, 1972, Reference Issue of the *Illinois Medical Journal*. An amendment to the Constitution, which involves only a rearrangement of the sections of the Constitution, was presented to the 1972 House and, according to constitional provisions, will be voted upon during the 1973 session.

At its October 13, 1972, meeting the committee recommended several amendments to the bylaws, including creation of a Council on Affiliate Societies to provide liaison between ISMS and the various specialty organizations in Illinois. These will be presented to the House of Delegates in resolution form.

Fredric D. Lake, *Chairman*

Herbert Dexheimer — Warren D. Tuttle
Allan L. Goslin — Paul W. Sunderland, *Consultant*
A. Edward Livingston — James Fletcher, *Consultant*

COMMITTEE ON COMMITTEES

As a member of the Committee on Constitution and Bylaws, the chairman of the Committee on Committees participated in developing the bylaws amendments being presented to the 1973 House of Delegates. The Committee on Committees has reviewed the proposed amendments pertaining to committees and councils and recommends approval.

Allan L. Goslin, *Chairman*

George Shropshear — Philip G. Thomsen

GOVERNMENTAL HEALTH PROGRAM REIMBURSEMENT

The Committee on Governmental Health Program Reimbursement (formerly called Committee on Health Care Financing) was recently reactivated to consider all problems of physicians reimbursement by Medicare, Medicaid and CHAMPUS. Committee members meet with representatives of the governmental health programs to discuss problems involving general policy, as well as specific cases brought by ISMS members.

At the committee's first meeting, a proposed new claim form developed by the Illinois Department of Public Aid was considered. The bookkeeping time required by physicians to complete the new form will be substantially reduced. This new claim form should be in use by March, 1973.

The committee also requested IDPA to stop its practice of arbitrarily setting fee levels and to permit ISMS and local medical societies to have a voice in determining the basic principles upon which such fee levels are established.

Committee members met with representatives of IDPA and the Illinois Department of Mental Health to discuss reimbursment to psychiatrists. The Committee was told that IDPA and IDMH staff, have worked out an agreeable policy under which IDPA would pay for psychiatric emergency room services at the same rate paid for other emergency room visits, and also pay psychiatric care for partial hospitalization at the approved outpatient rate, or the approved clinic rate.

Joseph R. O'Donnell, *Chairman*

Herbert Dexheimer — Philip G. Thomsen
Eugene P. Johnson — Frederick E. Weiss
George Shropshear

Jacob E. Reisch, *Consultant*

POLICY COMMITTEE

Following the annual meeting, the Policy Committee studied the many resolutions that contained policy considerations. With some modifications to avoid any inconsistencies, the final statements were submitted to the Board of Trustees for approval. After thorough discussion, the appropriate action placed the policy matters into the up-dated manual which will be distributed at the ISMS Annual Meeting

It should be emphasized again that *all* proposals which contain policy change or direction, must be contained in a resolution so that they may receive Reference Committee and House of Delegates Consideration.

Joseph L. Bordenave, *Chairman*

Andrew J. Brislen David S. Fox

PUBLICATIONS COMMITTEE

The year 1972 was one of challenge and stimulation for the *Illinois Medical Journal* and the Publications Committee. *IMJ* was published on a regular basis with no delays for any issue. The total number of pages printed was 1,188. This is a decline of almost 10% over 1971. The average issue consisted of 98 pages.

Previous determination of the Publications Committee indicated that a minimum of 96 pages per month would be essential to guarantee a well-balanced *Journal.* This was achieved during the year. Of course, advertising determined to a great extent the pages available, as it has in the past.

The content balance of the journal, 40% advertising, 40% medicine and 20% organization, was maintained within a close tolerance. This is in keeping with previously established guidelines. However, advertising occupied only 36% of the total pages printed.

In evaluating this year's operation, it would have to be said that the operation of the *Journal* was successful. However, it has been somewhat disheartening to witness a continued reduction in advertising revenue and steps were taken to improve this situation. This will be reported later.

Circulation

During 1972, *IMJ* was distributed to all residents, interns, and members of SAMA in Illinois, according to action of the House of Delegates. This increased circulation so that the average monthly distribution exceeded 15,500. This activity will not be continued in 1973 since action of the 1972 House allows full membership in ISMS of these individuals. Therefore, the *Journal* would be furnished as a service to that membership. It is anticipated that the average monthly circulation of 1973 will be in the vicinity of 12,700. Included in this would be distribution to the accredited hospitals in Illinois, exchange and complimentary copies to sister medical societies, the pharmaceutical industry, foreign and domestic subscriptions in excess of 200, and other bulk sales, through subscription process, with libraries.

Advertising

Imperative to maintaining a good journal is the acceptance of advertising, which helps in producing the clinical section of the magazine. It is important to continuing the format which has been developed over the last two years.

Unfortunately, 1972 witnessed a continued decline since 1967. Net revenue was something under what was anticipated; initial planning had anticipated recenue approximately 10% higher. Many factors could be identified which contributed to the decrease in advertising. It would be superfluous to deliberate what all these might be at this point.

However, recognizing that there was a need to increase advertising revenue, the Publications Committee, early in 1972, began exploring the possibility of hiring a space representative firm to represent the interest of the *Illinois Medical Journal* and to gain advertising for the magazine. After some five months of exploration and deliberation, the committee recommended to the Board of Trustees, which concurred, that arrangements be made to contract with United Media Associates, of Greenwich, Connecticut, to represent the *Illinois Medical Journal.* Some internal changes in personnel were effected, and UMA began work for *IMJ* as of August 1. Initial results were low, since it was necessary for UMA to establish itself as our representative and to build a sales package. Some accounts were salvaged while a few others were lost. Initial indications for 1973 indicate that early in the year an upturn can be expected.

Advertising rates were reviewed again in 1972, as required. A study of basic expenses, increased postal rates, labor costs, material costs, and other matters, indicated that there was no need to increase advertising rates on the basic rate structure. However, there was a need to make some slight adjustment in the display ad rates and in the classified advertising rates. These amounted to an increase of less than 2%. On this basis, the direct production costs of the *Illinois Medical Journal* will be covered by advertising revenue.

Internal Revenue Service Audit

As has been reported in previous years, the Internal Revenue Service has been trying to establish that revenues of the *Illinois Medical Journal* are to be considered as ISMS income unrelated to the exempt function of the organization. On this basis, advertising revenue would be taxable as a profit making publication would be taxed. Last year it was indicated to the House in the Annual Report that a tax liability of $30,500 had been fixed against the *IMJ.* After another year of discussion between IRS agents and ISMS, it has been agreed that the ISMS would make a payment of $2,500 against any tax liability. However, payment of this in no way admitted liability on the part of ISMS and after the statute of limitations expires, it is possible to file for a complete refund of this payment.

Here again, this report is in the form of a progress report or a status report. The final outome probably will not be known for another two years.

Publication Improvement

The Publications Committee has continued to review the content of *IMJ* and to suggest modification in typography, layout, feature sections, and so forth. The thrust has always been to present a magazine of interest and use to the membership. I am sure all will agree that the *IMJ* has decidedly improved over what it was several years ago.

Another improvement in communications was the inception of a bi-weekly newsletter entitled "Action Report." This brief newsletter type publication has been sent on a request basis to over 4,200 physicians twice a month, first class mail. By this means it has been possible to alert physicians to hot topics where immediate action, notice or response was necessary. The cost of producing this publication is quite high. However, as a service to the membership, it has been decided that this is a means to allow quick communication so that the membership may work in concert on matters of mutual concern. The entire production of this is accomplished within the headquarters office so there is a minimum cost for outside services. The Public Relations

Division puts the editorial matter together, the Publications Division assumes responsibility for all printing, production and distribution. The Springfield Regional Office cooperates by maintaining the address list. This is a classic example of what can be accomplished through dedicated, cooperative effort on the part of the various committees, councils and staff.

Conclusion

Needless to say, it has been an interesting year for the publications of ISMS. Some basic changes have been effected; some additional activities have been accomplished; some challenges have been presented which could have been disheartening; but, in the final analysis, it has been a most successful year. It has been a pleasure for the committee to work with the staff to continue to improve the communication links between the members and to continue to produce a recognized, accepted source of continuing education through the pages of *The Illinois Medical Journal.*

Jacob E. Reisch, *Chairman*
Warren W. Young — Glen Tomlinson
Eugene T. Hoban — Frederick E. Weiss

Editor of the *Illinois Medical Journal*

As an educational tool, the *Illinois Medical Journal* continues to keep Illinois physicians abreast on clinical medicine, continuing medical education and organized medicine.

A breakdown of the principal editorial pages for 1972 is as follows (minor items have not been included):

Clinical Medicine:	
Clinical articles (in 17 specialties)	147.25
Surgical Grand Rounds	36.75
Viewbox	15
EKG of the Month	15
Cooper Quiz	2
New Pharmaceutical Specialties	10
Maternal Death Study Case Reports	12.5
Trauma Center	41.75
Editorials	13
Book Reviews	4.5
Organizational Content:	
President's Page	13.75
Socio-Economic	5
Pulse of the Doctor's Wife	14
Peer Review	3
Legislation Report	5
Abstracts of Board Actions	16.75
Convention-Delegates Handbook	81.75
Convention Summary	13
Reference Issue	115
Doctor's News	21

New features added to the *Journal* this past year were "Doctor's News" "The Cooper Quiz," "Investment Corner" and "Maternal Death Case Report."

My sincere thanks and appreciation to the contributing doctors: Leon Love (Viewbox); David R. Boyd (Trauma Center); John R. Tobin, Patrick Scanlon, John Morgan and James Talano (EKG of the Month) and John Beal (Surgical Grand Rounds).

It has been my pleasure to continue to serve as editor of the *Illinois Medical Journal.* My deepest thanks to the staff members who devote their time and skill producing this *Journal.*

Theodore R. Van Dellen, *Editor*

President's Night

Honoring

Frank J. Jirka, Jr., M.D.

President

Illinois State Medical Society

Tuesday, March 27, 1973

Boulevard Room

Conrad Hilton Hotel

6 p.m. Reception

7 p.m. Dinner

Featuring Franz Benteler and

the Royal Strings

Committees Reporting to the Board

Drugs and Therapeutics

The Committee on Drugs and Therapeutics met several times during the past year to refine the drug list contained in the Drug Manual of the Illinois Department of Public Aid. Countless hours were spent in reviewing physician's requests for drugs not listed in the manual, in an effort to keep the Manual current and effective. The necessary deletions and additions were made.

At the present writing 3,000 written requests for drug usage have been received by the Committee. Numerous requests from pharmaceutical companies have been reviewed and action taken at their request.

The Committee reviewed the proposed FDA Rules on prescribing medications according to information on package inserts and, at the request of the ISMS Executive Committee, filed its objections with the Department of Health, Education and Welfare. The communication in part reads, "The Committee has the utmost concern for the patient's safety as to adverse drug reactions and over-utilization of drugs. Should the FDA proposed rules go into effect, adverse repercussions can occur that may be harmful to the patient and increase the cost of health care. The proposed FDA package inserts would prevent physicians from using an effective agent at an effective dose level in a patient who requires larger dosages. Moreover, such package inserts would inhibit the physician in using a drug in combination with another drug. We believe the package insert should be informative and *not restrictive* in the care of patients." Copies of the letter were sent to Senators Percy and Stevenson. Both legislators agreed to look further into the matter.

In response to Senator Percy's inquiry to the Department of Health, Education and Welfare, a copy of a letter from Gerald F. Meyer, Director, Office of Legislative Services was received. It stated in part, "because the matter is still only a proposal, and no final regulation has been issued, it is not possible for us at this time to comment definitively on the questions raised by Doctor Muehrcke. I can assure you, however, that we certainly recognize the problems Doctor Muehrcke discusses and can assure him that the proposed regulation is not intended to interfere in any way with a physician's choice of what he regards as the best treatment of his patient."

The Committee appreciates the cooperation it has received from physicians as a whole. It welcomes their comments and will be guided by their sound therapeutic suggestions when making recommendations to the IDPA for future revisions of the "Drug Manual."

Robert C. Muehrcke, *Chairman*

Joseph D. Cece	William H. Walton
Charles R. Frazer, Jr.	Andrew Krajec
Richard L. Landau	Arthur Marks

Consultants

Louis Gdalman, R.Ph. Bruce Flashner Richard Suhs

INSURANCE COMMITTEE

Since the last annual meeting, the Insurance Committee has spent many hours attacking the problems connected with professional liability insurance. In April, the Employers-Commercial Union Companies, underwriter of the ISMS-sponsored malpractice insurance program, announced that effective June 1 premium rates would be raised substantially for policy-holders in all classifications. Independent actuaries retained by the administrator, Parker-Aleshire & Co., supported the company's position that rising claims and judgments against participants necessitated the rate increase.

When the committee reported that the proposed rates amounted to an increase of more than 200% in some instances, the Board of Trustees appealed to the state insurance director, the governor and even the President for relief. Eventually, after Dr. Jacob E. Reisch, ISMS secretary-treasurer and a consultant to the Insurance Committee, appeared before the U.S. Price Commission to complain that the rates were discriminatory against physicians who were not permitted to increase their fees more than 2.5%, the rates were adjusted downward slightly, bringing the overall increase to 125%.

For almost a year prior to implementation of the rate increase, the Insurance Committee had been carrying on discussions with Johnson & Higgins of Illinois, Inc., insurance brokers, regarding the possibility of negotiating a new malpractice insurance program for ISMS members. In May the Committee arranged for J & H to appear before the Board of Trustees, where the company was given authority to make a six-month study of the malpractice claim problem in Illinois. The results of the study were made known to the Insurance Committee in December and a formal proposal for a new program was presented in January, 1973.

On the same day that the committee received Johnson & Higgins' preliminary report, the committee was notified by Parker-Aleshire that the carrier, Employers' Fire Insurance Co., would terminate the present program May 31, 1973. In its official communication, the company stated that "After a comprehensive review of our overall professional liability insurance undertaking, we have concluded that we must cease being major insurer of medi-

cal professional liability insurance."

Parker-Aleshire immediately proceeded to secure the services of another underwriter so that there would be no interuption in coverage for paticipants in the ISMS program. However, the committee decided to investigate what other avenues might be open. Accordingly, at its January meeting, the committee received the following proposals: (It should be noted that six months earlier the Insurance Committee had spent two weeks searching in vain for other insurance companies who might be interested in the ISMS program):

1. A Physicians Protection Program, with Marsh & McLennan, Inc, as national administrator; Clifton L. Reeder, M.D., local administrator, and underwritten by CNA/Insurance.

2. A Physicians Professional Liability Insurance Proposal, submitted by Johnson & Higgins of Illinois, Inc., representing the Hartford Fire Insurance Company.

3. A Professional Liability Insurance Program, proposed by Frank B. Hall & Co. of Illinois (administrator) and Argonaut Insurance Company (underwriters).

4. A Professional Liability Program, with Parker-Aleshire & Co. as administrator for Chubb & Son, Inc.

The committee is expected to present its recommendations to the Board of Trustees well in advance of the expiration of the present malpractice insurance program.

Life Insurance Program

After learning that many physicians were subscribing to unsponsored life insurance programs through direct mail solicitations, the Insurance Committee reconsidered its previous position on offering life insurance to ISMS members at group rates. Accordingly, the committee invited several agents to submit proposals for a group life insurance program. Two brokers made presentations. A. W. Ormiston & Co., which submitted figures from five different underwriters, was chosen to administer the program for the Northwestern National Life Insurance Co. This program was subsequently approved by the Board of Trustees and offered to members during the past summer. Approximately 1,000 were enrolled.

Business Overhead Expense Insurance

The Insurance Committee obtained approval of the Board of Trustees for a program of Business Overhead Expense Insurance to be offered to ISMS members. This program, to be administered by Parker-Aleshire & Co. and underwritten by Provident Life and Accident Co., is to be offered to members early in 1973. It provides for payment of heat, light, employees' salaries and other expenses when a policy-holder is sick or disabled for more than 30 days. Several other brokers were invited to bid on this business before Parker-Aleshire's program was accepted.

Retirement Investment Program

During the year the committee also authorized the Paul H. Robinson Co., administrator of the ISMS Retirement Investment Program to conduct a mail solicitation which brought total participation to 103 members. The Robinson Co. also administers the society's Tax Qualified Retirement Program (Keogh Plan), and Hospital Income Program, which has 769 participants. A new enrollment period is planned for the latter some time during the summer of 1973.

Major Medical and Disability Insurance

The other insurance programs monitored by this committee are a major medical plan and disability insurance. A new enrollment period with additional benefits for the disabled was offered to members early in 1973.

Members Moving Out of State

Since ISMS now sponsors so many different kinds of insurance for its members, the Insurance Committee saw an obligation to provide for continued participation by members who move out of state. Accordingly, it instigated a proposal to amend the ISMS bylaws to allow physicians leaving Illinois to maintain membership and qualify for ISMS-sponsored insurance for a period up to a year. This amendment, which will be presented to the 1973 House of Delegates, is designed to give physicians time to join the medical society where they have moved and to enroll in whatever insurance programs may be available there.

Lawrence Knox, *Chairman*

Philip Boren — A. Everett Joslyn
Martin Compton — Ted LeBoy

Consultants

A. Edward Livingston — Jacob E. Reisch
Fred Z. White

SPECIAL PROJECT COMMITTEE, ILLINOIS DEPARTMENT OF MENTAL HEALTH

During 1972, specific problems relating to limited license physicians employed by the Illinois Department of Mental Health were called to the attention of ISMS. In order to address this concern, the Board established a small liaison committee to meet with representatives of IDMH. The purpose of this group was to identify problem areas and to develop alternatives and suggested solutions.

In order to accomplish the purposes of the committee, two small sub-groups worked on two specific activities. First among these was development of communication between the IDMH units at the local level and the county medical societies. The outcome of this discussion was development of a resolution to be introduced at this session of the House of Delegates, which would indicate activities for the local county medical societies as they work in cooperation and conjunction with local units of IDMH. By this means, it was felt the local county medical societies will have greater interest in what is being accomplished in the mental health institutions in local areas.

The second item of consideration dealt with permit doctors. Recent legislation will cause the current system of limited license physicians to be eliminated as of June 30, 1975. At that date, only fully licensed physicians will be allowed to perform physician services in state mental hospitals. However, over 200 permit physicians exist within that system. All of these individuals have specific training which could be utilized. To this end, there has been discussion regarding development of categorical job descriptions. By this means, individuals may be placed into specific functions according to their level of experience and expertise. Minimum educational standards would be dictated and those who continue to improve educationally eventually will be able to take appropriate licensure examination to be come fully licensed. By this means, upward mobility will be guaranteed. This matter continues in development.

This is the basic thrust of this sub-committee. It is a challenging task. Hopefully over the next year the answers to the problems posed by the permit doctor system may be determined.

John Ovitz, *Chairman*

Morgan Meyer — LeRoy Levitt

Ancillary Organizations

ILLINOIS COUNCIL ON CONTINUING MEDICAL EDUCATION

In his inaugural address as ISMS President before the 1969 House of Delegates, Dr. Edward W. Cannady planted the seed that was to grow into ICCME. Following careful analysis of alternatives, the 1970 House of Delegates endorsed the principle of a multi-organizational approach to continuing medical education. The next ISMS President, Dr. J. Ernest Breed, vigorously cultivated the seedbed; and the 1971 House of Delegates supplied the nutrient essential to growth by approving financial support for the new plant.

The past twelve months saw the flowering of that seed: the Council members were appointed and completed basic organization, an Executive Director was employed, and a first set of operational goals were adopted. By December 31, 1972, the Council was actively pursuing the purposes for which it had been established.

ICCME represents a concept unique among contemporary professional groups and among states:

1. The new organization is *independent*—and thus able to serve *all* interests concerned with the professional self-improvement of Illinois physicians. It provides the mechanism for combining and co-ordinating *all* available resources.

2. Its chief function is to *encourage* and *co-ordinate* learning opportunities for Illinois physicians, rather than directly sponsor such opportunities. It thus has time and energy to search out new approaches and ideas, and provide crucial channels of communication among all CME programs.

3. It provides a dynamic framework on which to build programs to meet emerging future needs (*e.g.*, registration qualifications).

Throughout the planning stages, prodigious efforts were made by both the ISMS members and the deans of the State's medical schools to develop the best possible organizational pattern for achieving ICCME's stated goals. These efforts and this careful planning began to pay off with rapid action during 1972:

January and February: The ISMS Board of Trustees appointed the Society representatives to the Board of the new Council, designating Dr. Breed as Chairman *Pro-Tem.* Each medical school dean also appointed a representative.

March: The complete Board held its first organizational meeting and appointed a committee to search for an Executive Director. The official Charter was obtained from the Illinois Secretary of State.

April: A wide range of possible Council activities and directions were discussed by the Board; a committee to nominate permanent officers was appointed.

May: The Board adopted by-laws and defined qualifications for an Executive Director.

August: Leonard S. Stein, Ph.D., was appointed Executive Director. He is a professional adult educator with 24 years' experience at The University of Chicago, St. Louis University, and Adelphi University. His background includes program-planning for a variety of professional groups, including physicians, dentists, and nurses.

September: The Executive Director began work. A formal budget was adopted for the balance of 1972, and house-keeping details were settled (selection of auditor and counsel, escrow funds received from Educational and Scientific Foundation, bank accounts opened, *etc.*). ISMS provided office space and basic equipment.

The new Executive Director also began a series of visits to the eight medical schools, to hospitals, and to other health organizations, establishing good relationships throughout the state.

November: The Board adopted a set of priorities for initial attention, as well as a longer list of ideas for future consideration.

The priority items are to:

1. Study logistics, manpower, and resources, by establishing a map of the State listing hospitals, medical societies, number of physicians, and other information pertinent to our goals in a master plan for Illinois physicians.

2. Organize quarterly meetings of hospital Directors of Medical Education (DME) and others interested, in various parts of the state, for exchange of ideas and information.

3. Offer consultation with hospitals, county medical societies, state specialty societies, and others on CME methods.

4. Maintain a central calendar of all CME activities in the midwest, aiming to help DME's and others coordinate activities to avoid needless duplication.

5. Offer to assit ISMS in preparing copy for "What Goes On: A Guide to Continuing Education" in the *Illinois Medical Journal,* to include (a) all upcoming CME courses in the midwest, as well as information on other learning opportunities, and (b) an invitation for ISMS members to request CME learning activities.

6. Publish a pamphlet "Planning Your Personal Learning Program" for use by physicians. Content would include (a) information on availability of learning opportunities and where to get specifics, and (b) a set of worksheets to assist the individual in thinking through his own learning goals.

7. Organize the first annual "Congress" on continuing medical education, tentatively set for mid-April, 1973 (a committee was appointed to plan details).

Other activities set down for consideration later in 1973 included:

Plans to organize a mini-residency program for practicing physicians in major medical centers, and a related *locum tenens* program for physicians who need this service

in order to get away for CME.

A survey of Illinois hospitals on their CME activities.

Consult with ISMS on providing aid in its activities that are primarily educational in purpose.

Seek a role in distributing and encouraging use of self-assessment tests.

Co-ordinate a "Visiting Professor" program.

Organize biomedical reading programs.

Develop an information system to maintain permanent data on physicians' CME participation.

Publish a periodic Newsletter on CME activities for county and specialty societies.

ICCME, ISMS, and the State's medical schools have achieved a working unity that can solve those problems confronting the medical profession that lend themselves to educational techniques. Illinois physicians now have at their disposal a new service, under their control, to enhance their own professional competence.

Richard Byyny, *President*

J. Ernest Breed, *Vice President*	John Graettinger
Robert Fox, *Secretary*	R. A. Kistner
Dean Bordeaux, *Treasurer*	LeRoy P. Levitt
Eli Borkon	Boyd McCracken
Herschel Browns	George Miller (proxy,
Joel Brumlik	1972-73, Don Pochyly)
Edward W. Cannady	Mather Pfeiffenberger
Willard G. DeYoung	George Shropshear

Jacob E. Suker

ILLINOIS SOCIETY, AMERICAN ASSOCIATION OF MEDICAL ASSISTANTS

The Illinois Society of the American Association of Medical Assistants has dedicated its efforts in projects to fulfill our association's objectives.

To further the education of our members as well as non-member assistants, we have provided informational programs throughout our state. These programs include a Knowledge Transfusion Traveling Course with speakers on emergency care, Medicare, office courtesy and telephone etiquette. These courses have been given in five localities.

In conjunction with the President's Tour, workshops have been co-sponsored with ISMS for medical assistants in seven areas. The topic of the workshops has been Medicaid and Medicare. Reservations at each site have indicated there is interest for information regarding the government program services.

In September, a state-wide education symposium was hosted in Joliet. Approximately 150 medical assistants participated in an Effective Listening Workshop and heard discussions on genetics, Lamaze birth techniques and venereal disease.

Personal development was the objective for a state-wide program held in Champaign. The topics included were Initiative, the Key of Accomplishment, Effective Speaking Workshop and promotion of association work.

A Medical Assistants Day is arranged at the ISMS Annual Meeting and Clinical Conference. A panel on child abuse will explore the legal, sociological and emotional aspects involved. Other speakers are Dr. David R. Boyd of Emergency Medical Service and Dr. Seymour Diamond, "The Headache Clinic."

The Illinois Society Annual Meeting held each April includes 1½ days of informational or educational workshops, or speakers to broaden our awareness and knowledge in this very complicated field in which we work.

As you can see, we have endeavored to keep the medical assistants well informed. We believe that through these projects, we become better trained and more knowledgeable; therefore, more efficient in our jobs of keeping your offices running smoothly.

At present, there are 27 active chapters providing a local association available to medical assistants in 32 counties. Attention is directed to growth at all times. Contacts have been established with several other counties and we anticipate additional chapters will be formed within the next year.

In closing this report, I would like to express our appreciation to Dr. Frank Jirka, Jr. He has been generous in his support. We are indebted, greatly, to Dr. Carl Clark, our ISMS Liaison, and the Illinois Society Physician Advisors for their assistance and guidance. The staff of the ISMS Executive Office has been most helpful and cooperative. We are cognizant of the value this assistance makes to our society's progress and will continue to develop more and greater rapport through the local, district and Illinois State Medical Society .

Mrs. June Hall, CMA

President

PRESIDENT OF THE WOMAN'S AUXILIARY

Under the theme "Getting to Know You" we have worked to show our concern for health education in the community and to promote mutual understanding among physicians' families. We have emphasized the areas which the WA/AMA considered essential this year, namely, legislation, nutrition, safety, health careers and membership.

The WA/AMA's 50th Anniversary and the AMA Quality of Life Conference, and the AMA-WA Health Education Conference (hosting Julie Nixon Eisenhower and Mrs. Richard Ogilvie), plus being the United States presidential election year influenced the auxilians to another productive year. Further, to add to the list of success, are the three past presidents serving at national level: Mrs. Willard Scrivner, Mrs. Wendall Roller, and Mrs. Sherman Arnold; plus Mrs. Eugene Vickery, a contributing editor for *MD's Wife* publication.

The variety of community health education projects undertaken by the county auxiliaries increases each year. This year the DeKalb County handled several areas, mainly nutrition education thru seminars; plus the distribution of the brochure, "A Guide to Good Eating," and "Timely Tips on Health and Safety"; articles on "Nutritional Responsibilities" and "The Menance of Mal-Nutrition." Mainly, the program was designed to bridge the gap between rapid advances in genetics beginning with the fetus to the aged, nutrition and health education and their application in the family unit. A few auxiliaries serving meals to the homebound are Stephenson, St. Clair, McLean, Lee and Knox.

Cook County's strong areas are Meals on Wheels, assistance to World Medical Relief, Benevolence, and AMA-ERF along with taping books for the blind and linguist clinics for the foreign students.

Winnebago raises funds for the Goldie Floberg Home for handicapped children. The women serve as public health volunteers in the areas of family planning clinics, nurses and technicians in clinics, and testing of preschool children for learning disabilities.

Will-Grundy County Medical Auxiliary's project "Time Bank" was chosen as the outstanding community project in the State of Illinois for the 1972 National Convention. Time Bank co-ordinates the services and hours volunteered by members of several community organizations and individuals. A roster with time and talents makes the volunteer available when one is needed to provide transportaiton to the doctor's office, run errands, visit the elderly in nursing homes, or any other health care need. She is called by the "telephone volunteer" who has received the call for assistance from a commercial answering service. Time Bank is a model of community self help. It has proven that a sincere desire to help others coupled with limited amount of funds can accomplish a great deal.

Sangamon County's International Health project was to benefit the An-Loc Orphanage for children in Saigon. Kankakee was active in many areas and stressed the Health Careers program.

Peoria compiled, printed and distributed a comprehensive glossary of health related careers. The information includes a brief job description, a statement of the educational level required and a mailing address for further information relating to each specialty. The glossary is given to councilors and placed in school libraries.

Madison County covers many varied programs and stands out by contributing clothing and household articles to the American Indians on the Lane Deer Reservation in Montana. McLean County's catchy title of "Patch the Pony" a safety project to carry the message of safety rules to small children has reached 2,000 kindergarten children.

Jefferson-Hamilton stands out for special services with the Cancer Loan Closet. Dressings are furnished to patients. Hospital beds, wheel chairs, and walkers are available on a loan basis. Plus, they sponsor the new Ostomy Club and The Mastectomy Rehabilitation Program. The home economics course taught at the high school covers the topics of alcohol, smoking, drug abuse, mental health, sex education, teen-age venereal disease and youth health and fitness.

In addition to financial support of Threshold the primary project of the Champaign County Auxiliary, is to help the Threshold Resale Shop be restocked with donations of used items. Other auxiliary projects include raising enough money to send two children to summer camp, plus donations to Gemini, HOPE, & AMA-ERF. Threshold is a day treatment center for emotionally disturbed adults. The resale shop is part of the treatment program. It provides a means for social contact and helps these adults to gradually make their way back into society. Its social rehabilitation program has been in operation since March, 1967.

Boone County proudly sponsors the old fashioned Future Nurses Club. Adams County sponsored a panel on drug abuse as a community service for leaders of Girl Scouts, Boy Scouts, representatives of the schools and the YMCA. One hundred and thirty were in attendance and told they would use the programs respectively. The Medical Careers Club continues to be active with an average of forty at each meeting.

Belleville-St. Clair gives financial assistance to the "Magic Lantern" program of the Young Womens' Christian Association of East St. Louis, which provides group learning activities for children ages five through eight. The children and youth programs include children's summer camp, Block Parent, and Helping Hand Programs, and Health Records and Immunization.

The Religion and Medicine Chairman was active with the new approach presented at the National Convention of WA/AMA by Masters and Masters, of St. Louis, Mo., on the natural anatomical and biological needs of man; plus the effects of social culture hang ups and how, in fact, it affects every couple in one way or another in the natural function of reproduction.

Most impressive of all is the fact that almost every county auxiliary sponsors a scholarship or loan program. These monies are raised thru benefits, dances, bridge parties, fashion shows, tours of homes and art centers, teas and receptions, husband-wife dinners, and family picnics. At the same time it offers the medical family a chance to get acquainted at a lovely social function.

Through our International Health Activities Program, we extend our friendship to doctor's families around the world and show them we care. New this year is the Pen-Pals friendship program, corresponding with physicians and families in other lands—names are available from the chairman and SKIP (Scholarships for Kids of International Physicians) this allows a physician to go into the Hinterlands while his child goes to a private school.

We are indebted to the Flying "99's" who have helped us by transporting supplies to collection centers where they can be shipped to missions and doctors in other parts of the globe. This is another example of co-operating with other agencies to improve the health of all people.

February, 1973, marks a new era for the Health Manpower Programs in Illinois. County Auxiliaries under the financial sponsorship of Americana Health Care Centers will innovate Health Manpower Commissions at the county level. "Altogether in Health Careers" has been the theme of our State Program for the past two years. Representatives of all health oriented organizations will work TOGETHER toward a common goal of fulfilling the needs of the health manpower profession.

The health care industry is the largest industry in our country. The Health Careers Council of Illinois will serve as our model in organization. It is composed of all health centered organizations who work together to try to present unified programs. Our mini-commissions also will try to standardize programs and avoid duplication. Americana Health Care Centers is vitally interested in the communities they serve and the standards of health care for their patients. Therefore, they have consented to help us solve the problems of our health manpower needs by giving financial and organizational support. We are most grateful to them for their concern and their assistance. County auxilians will act as the catalytic agent for the organization and operation of the Health Manpower Commissions.

Our legislative slide presentation, which was featured at all our district meetings, worked effectively to inform the members on the structure of the state and national congress. It delineated the procedures to follow to run

for a government office and the intricate maze of electing a senate leader, a whip and a majority leader. Our Springfield staff discussed in detail how to effectively approach elected officials. Women can and have proven to be good workers in political campaigns and are sought after; no doubt because they have more free time. Regardless of the fact it was an election year, this has been an exciting and responsive legislative year in work and results. Everyone is concerned with increasing government influence and control of the medical field.

WA/AMA has asked our help in promoting legislation that will keep the practice of medicine open and retain the doctor-patient relationship. State Political Action Committees have been formed to educate our members and to offer support for candidates who will express medicine's point of view. Medi-credit has been developed by the AMA as a means of providing needed medical care for those who cannot provide it for themselves. We also have "*L*egislative *E*ffort Group *S*ystem" (LEGS)—a pyramid system that can be put to work immediately. To use the "LEGS" system, the key person makes one phone call to the State Legislative Chairman; she in turn, phones the 36 legislative chairmen; they in turn phone the member—where all the action begins—totalling 3100 letters or telegrams directed to a cause. This is a continuing program, beginning all over again with the 93rd Congress in 1973.

American Medical Association Educational Research Foundation Projects were successful this year. Illinois leads in funds for Medical Study. The 50th Anniversary glasses, charms, and hooks, were added to other fund raising items of Christmas cards, watches, book-ends note-pads, umbrellas and In Memoriam cards. The foundation raises funds to back guaranteed student loans and provide grants to medical schools to enahle them to educate more students in the study of medicine.

The American Medical Association and Auxiliary has backed over 70 million dollars worth of loans in the past ten years. **Illinois has led the entire country in contributions for the past four years by raising and donating $215,765.02 in 1972.** There is a new limited loan fund for minority group medical students started last season with a grant from the Sloan-Kettering Foundation which requires no interest payments at all. The fund will be enlarged as donations are received, and the AMA-ERF invites contributions in any amount from local industry and the public-at-large.

We are proud of the county auxiliaries support of the Benevolence Fund to the Illinois State Medical Society which was established in 1949. Every auxiliary member contributes one dollar to the Benevolence Fund. This fund is open to doctors and their families. Such emergencies as total illness of a young physician or death entitles the family to be covered by Benevolence. Today, 30 recipients, 28 widows and two physicians, average $100 a month. Only the members of the Benevolence Committee know who the beneficiaries are.

With 102 geographic counties in Illinois and 36 counties organized, comprising 3100 members including members-at-large, membership has been of primary concern. Special attention has been on retention, revitalization and recruitment of physicians' wives. Arrangements were made well in advance to visit as many county auxiliaries as possible from early September through November, resulting in 13 visits and four on the books for April, 1973. This list was posted and a general invitation to attend was extended to the State Board including the district councilors, all county presidents, general members and members-at-large. The most significant outcome of these personal visits was a renewed interest and purpose. The county presidents recommended the practice be continued.

To spark a competitive drive for membership, circulars were issued in April, 1972, and mailed to every member, the awards to be presented at the 1973 convention. The categories for awards are: 1) to the individual president obtaining most members; 2) to the counties with the greatest percent of increase in membership; 3) to those counties which become 100% during 1972-73 and 4) to the councilor who organizes a new county. A special award will be given to the councilor who organizes three counties.

This year for the first time a 1973 members-at-large state directory has been compiled with the home address of the physicians' wives that are members-at-large according to districts of the approximately sixty counties without an auxiliary. This enables communications to be sent directly to the wife.

The combined district meetings for the State were: Districts 1, 2, 3, 11, on September 12th at the American Medical Association Office; Districts 4, 5, 6, 7, 8, on October 17th at the Ramada Inn in Peoria, and 9 and 10 has backed over 70 million dollars worth of loans in the on November 9th at the Belleville-Clair Fairgrounds, Belleville.

We have representation on the ISMS Committees of Benevolence, Safety, Home Centered Care, Mental Health, Press, Legislation, Public Affairs, Membership, Religion and Medicine.

The Woman's Auxiliary to the Student American Medical Association will be holding their National Convention at the Palmer House in Chicago May 3-6, 1973. Illinois has two auxiliaries Stritch and Peoria; one is being organized in Rockford.

Although we lost our Pulse Newsletter in April, 1972, the ISMS has allowed the Auxiliary to bring their news through the *Illinois Medical Journal* monthly. We are investigating at this time new ways to finance a publication to keep our members abreast of activities.

In reviewing the entire year the accomplishments were outstanding. No doubt about it, the roll of volunteer equates to the Woman's Auxiliary to the Illinois State Medical Society. These wives of doctors give of their hearts, talents, and loyalty to help make their communities a better place to live. This was a rewarding year. Finally, and most appropriately Winston Churchill said, "the further back you search the better the future looks."

Mrs. August Martinucci
President WA/ISMS

Visit the Exhibits.

Economics and Peer Review

COUNCIL ON ECONOMICS & PEER REVIEW

The Council on Economics & Peer Review was given greatly expanded responsibilities during the past year. It continued to serve as the state appellate body for peer review and delegated this function to a Peer Review Appeals Committee. In addition, the Council acted as liaison with Medicare and Medicaid; established relations with the Comprehensive Health Planning Program and the Illinois Regional Medical Program; and sought information about the new health care delivery systems being formed in Illinois.

Highlights of the Council's activities during the year were as follows:

1. considered proposed legislation that will permit surgi-center or free-standing clinics to function—the proposal will enable insurance carriers to include coverage for services provided in surgi-centers;

2. evaluated the Illinois Department of Public Health's MEDICHEK program which will provide preventive health care for disadvantaged children—the Council recommended ISMS endorse this program contingent upon the principle that physicians will be reimbursed on the basis of their usual, customary and reasonable fees;

3. requested all insurance carriers to pay physicians for assisting at surgery if billed or certified separately;

4. considered the development of current fee profiles and recommended the updating of an Illinois relative value study based upon the usual, customary and reasonable fee concept;

5. recommended that local peer review committees charge a flat $15 rate per case for review to cover administrative costs—this rate could be adjusted by the local county if costs on a particular case became excessive and

6. recommended an ISMS policy statement on HMOs.

In addition to these activities, the Council was responsible for a government health program workshop for medical assistants. Medicare and Medicaid representatives presented an educational program to approximately 700 medical assistants at various locations throughout the state in conjunction with the ISMS' President's Tour.

The Council met with the Illinois Regional Medical Program representatives and recommended that a meeting be arranged between ISMS, IRMP, and the Illinois Foundation for Medical Care to explore subjects of mutual interest, especially in the area of quality care programs. The Council also met with Comprehensive Health Planning officials to discuss establishing ongoing liaison between ISMS and CHP.

Peer Review Appeals Committee

The Peer Review Appeals Committee was formed from members of the Council on Economics & Peer Review, in order to create a smaller and more flexible appeals review mechanism. The Committee consults with the various medical specialties whenever this is necessary to obtain information on specific matters.

During the year, the Appeals Committee considered five cases submitted by physicians, patients or third party payors. These cases had previously been heard by local medical society peer review committees.

The Committee also considered revising the present peer review guidelines. It was felt revisions are necessary and would make the guidelines more relative to current practices. In this regard, the Committee suggested that a definition of "medical community" be established so health insurers could utilize a standard base for determining prevailing fee areas.

Council

Fred A. Tworoger, *Chairman*

Charles E. Baldree, Jr.	R. Gregory Green
Edward DuVivier	Earl E. Fredrick, Jr.
John L. Eaton	Don Michels
Maynard I. Shapiro	George Perlstein

Robert J. Becker

Consultants

David Fox	Fred Z. White
Eugene P. Johnson	Joseph R. O'Donnell
Glen E. Tomlinson	Frederick E. Weiss
Wayne Domin, *SAMA*	Michael Sadove, *SAMA*

Peer Review Appeals Committee

Robert J. Becker, *Chairman*

Edward DuVivier	John L. Eaton
Earl E. Fredrick, Jr.	R. Gregory Green

ILLINOIS DEPARTMENT OF PUBLIC AID

Last year at this time, a financial crisis threatened the Department of Public Aid. The courts enjoined the IDPA from transferring funds from one program to another and taking steps to reduce medical expenditures.

During the past year "cautious optimism" has been growing. During the 12 months ending September, 1972, the overall caseload in Illinois rose 12.3%. In the preceding 12 months, the increase was 33.6%. Major administrative changes within the Department of Public Aid and the slowing in the rate of monthly caseload increases enabled the state to maintain benefits at a time when many states found it necessary to make cuts.

In September, 1972, public aid clients received the first grant increase since July, 1970. Covered by the increase were adjustments in the cost-of-living index of 6% for food, 9% for clothing, 9% for restaurant and home-delivered meals (for persons who are unable to prepare meals) and 3% for personal essentials (including limited public transportation and telephone calls, toiletries, first-aid supplies, school supplies and reading material.)

The Hospital Admission and Surveillance Program (HASP) initiated in January, 1972, significantly reduced the state's expenditures for hospital care without reducing the quality of medical care.

The most recent figures (September, 1972) for Cook County Hospital indicate public aid patients were staying an average of 5.6 days, which is a drop of 2.2 days from the year before.

Throughout the state, a decrease from 1.2 to 2.2 days was noted in the average length of hospital stay as compared to 1971 figures. At an average per diem of $125 in Chicago and $100 downstate, the days saved represent more than $12 million.

The September HASP report noted expenses of $250,000 for starting the program and $14 for each patient certified—a total of $866,000 in costs to the state. This placed the net savings as of September at $11.3 million.

Department job placement representatives helped over 6,400 clients find jobs in the eight-month period ending November, 1972. A recent study of the program indicated that clients were staying on the job. Over 93% of the persons placed in employment in June were still working 60 days later.

Expenditures of state funds in the state/local funded General Assistance Program began dropping in December, 1971, and savings have averaged an estimated $3 million a month since January, making a total of $18 million for the first six months of 1972. Much of this decrease can be attributed to a caseload review and transfer program in Cook County. Eligible recipients in Cook County were transferred to categorical programs (primarily Disability Assistance and Aid to Families with Dependent Children) for which Illinois can claim 50% federal reimbursement. Between June, 1971, and June, 1972, the number of persons receiving General Assistance decreased by 23,900.

IDPA is currently conducting a statewide face-to-face interview with more than 160,000 persons receiving Aid to Families with Dependent Children. Purpose of the review is to redetermine the current eligibility of assistance cases served by the department. Work will be completed and recommended actions on cases will be finalized by late spring.

IDPA has made a major breakthrough in curbing forgeries and stolen checks by offering clients photo cards bearing their pictures and signatures for positive identification to cash monthly assistance checks. Businesses cashing checks for persons having the cards can easily determine whether or not the check belongs to the person cashing it. Approximately 92% of public aid clients now have the photo cards.

The Department began paying for preventive health and dental care services for public aid-eligible children 0 through 5 years in February, 1972. A comprehensive program of outreach, health resource development, health education, and health record services called Medichek was to have gone into effect January 1, 1973, but may now be delayed until spring.

Medichek was originally developed by the Department of Public Health and was to have been administered by Public Health with Public Aid paying for services provided. However, the state legislature removed Medichek funds from the Public Health appropriation for Fiscal Year 1973 and placed them in the Public Aid appropriation. This necessitated a total realignment of procedures and delayed the original implementation date by several months.

A contract was signed between IDPA and the Illinois Family Planning Council in September, 1972, to make family planning services readily available to every public aid client who wants and needs them. The agreement gave the Council responsibility for setting up family planning clinics or other family planning services in neighborhoods and communities where these are not available. The Council will also act as a coordinating and referral agency.

A firm starting date for services has not been established because of numerous procedural and policy difficulties. Primary among these is the need for clarification of recent changes in federal funding of social services. Although the federal government will now, technically, pay 90% of the state's expenditures for family planning services, the funds expended will cut into ceilings set on reimbursements for social services. To handle the funding of the contract through Title XIX Medicaid, funds will require a waiver of state plan requirements.

Staff have been assigned responsibilities for clarifying these issues and completing the work necessary before the contract can be implemented. A target date has been set for early 1973.

The Social Security Amendments of 1972 federalized Assistance to the Aged, Blind, or Disabled (AABD) and established a national standard for these programs effective January 1, 1974. Clients who became ineligible for grants solely as a result of the October social security benefit increase will continue to be eligible for Medical Assistance until October, 1974.

As of July 1, 1973, Medicare will cover disabled persons under 65 years who are eligible for social security benefits.

Some of the less publicized provisions of the amendments in relation to Medicaid were:

1. Federal matching funds for long-term hospital care or skilled or intermediate care would be decreased unless the state maintains effective utilization control;

2. States deciding to pay an aged, blind, or disabled person an amount in addition to the federal social security income can do so and may require a period of residence in the state as a condition of eligibility;

3. In January, 1973, states will be required to impose monthly charges, related to income, on persons eligible for Medical Assistance (only) and nominal deductibles and co-payments (not related to income). For cash assistance recipients, deductibles and co-payments would be permitted for optional medical services such as prescribed drugs and hearing aids, but prohibited for the six mandatory services: inpatient and outpatient hospital services; x-ray and laboratory services; nursing home care; physicians' services; and home health services;

4. Beginning in January, 1974, an individual or member of a family eligible for cash public assistance and medical care who becomes ineligible for Medicaid because of increased earnings from employment would continue to receive medical assistance benefits for a period of four months from the date eligibility would otherwise terminate;

5. States are no longer required to broaden the scope of services and liberalize eligibility for the Medicaid program and are permitted to reduce their medical expenditures for public aid clients from one year to the next

6. The federal government will reimburse states in full for survey and inspection costs of skilled nursing and intermediate facilities under Medicaid for the period October 1, 1972, through June 30, 1974.

However, Congress failed to adopt provisions of H.R. 1, related to Aid to Families with Dependent Children (AFDC) which accounts for the highest portion of the nation's public assistance caseload.

Although the Department of Public Aid continues to face serious problems, significant progress in many areas has been made during the year; objectives for the months ahead have been established and action is being initiated to achieve these goals.

Edward T. Weaver, *Director*

Education and Manpower

COUNCIL ON EDUCATION AND MANPOWER

Since last reporting to the House of Delegates, the Council on Education and Manpower has studied several propositions, has recommended actions to the Board of Trustees, and has developed items for the 1973 House.

Action on 1972 Resolutions

Resolution 72M-1: this resolution called for support of the Federation of State Medical Boards and opposition to national licensure. This was related to the Federation and, in addition, testimony of ISMS President Frank J. Jirka, Jr., before the Health Care Licensure Commission supported these ISMS positions.

Resolution 72M-23: the AMA Council on Medical Education had proposed a "fifth pathway" for foreign-trained medical students, who are U.S. citizens, to enter American medical education systems. By this the foreign-trained student could come to the U.S. and take a one year junior internship or clinical clerkship under the aegis of a medical school. At the conclusion of this, an approved internship would be accomplished and the student could then become licensed in Illinois. ISMS supported legislation, more than a year ago, modifying the Medical Practice Act to allow equivalency testing to place medical students at an appropriate level when entering medical school with prior training. The Council recommended a resolution which was introduced at the AMA suggesting that the Illinois system be considered an alternative to the "fifth pathway." The AMA did not concur, but referred the matter to its Council on Medical Education for further study.

Resolution 72M-32: a petition to the governor was developed and signed by ISMS President Frank J. Jirka, Jr., recommending support for funding of medical education at the level approved by the Health Education Committee of the Board of Higher Education.

Physicians Assistant

During the year, and subsequent to action by the 1972 House of Delegates, much was heard regarding the assistant to the primary care physician, his education, certification, responsibilities and duties, and legal status. Legislation creating this category of health personnel did not pass the legislature. However, it is anticipated that another bill will be introduced in the 78th General Assembly. Needless to say, this is an emotional issue. This Council has listened to many arguments pro and con and has had physician assistant personnel describe their activities. The previous action of the House should continue to be supported, which would allow a physician in the private clinical practice of medicine to employ no more than two such assistants. This could necessitate modification of the Medical Practice Act to indicate the legality of delegation of duties. It might be wiser to modify the Nurse Registration Act to include these individuals.

Trauma Network

At several meetings this Council discussed the training of paramedical personnel being utilized in the state trauma network. The Dunlap Curriculum of the American College of Surgeons is being used as a basic 82 hour training course, supplemented by a 30 hour course in intensive cardiac care. These curricula were deemed appropriate. However, there are serious reservations regarding the persons conducting the training programs. In several instances, it seems physician input is lacking and the courses are being conducted by trauma coordinators, who are returned military corpsmen in many instances. This matter has been referred to the ISMS Committee on Emergency and Disaster Medical Services.

Rural Health

Regular reports have been received from the ISMS Representative to the AMA Congress on Rural Health. During the past year a report on the need to assist in developing liaison with planning agencies on the local level; to identify health needs in rural areas; and to try to get more new physicians into needy areas was received and referred to the Board of Trustees. Part of this will be implemented by the resolution being introduced by the Council on Environmental and Community Health in response to the Getting Report.

Student Notations

During the year questions arose regarding student notations on hospital charts and official orders. After lengthy deliberation, and review by legal counsel, suggested guidelines were developed and subsequently approved by the Board of Trustees. These have been circulated to all medical schools and hospitals in Illinois as a suggestion to help maintain good order in this matter and to guard against possible malpractice litigation based on notations made by students on official records.

Student Visitations

At the request of the Alumni Council of the University of Illinois, a visitation program was set up on a pilot basis whereby students could visit in the homes of physicians on weekends, in settings away from the city. Several physicians signed up for the activity, but students seemed somewhat apathetic. The project is being referred back to the Alumni Council since there is little that ISMS can do to generate more enthusiasm

among the students. This is a good idea which has not yet caught on.

Liaison to Council of Deans

In an effort to maintain close communication with the medical schools, a liaison committee has been formed with three ISMS members (from this Council and the Governmental Affairs Council) and four members of the Council of Deans. Problems of mutual concern are addressed and suggestions regarding curricula, projects, budgets, and like matters are discussed.

Funding for ASPIRA and Bio-Medical Careers

In 1971, three groups were assisted financially by the Task Force on Physician Shortage and Services to Medically Deprived Areas. These were ASPIRA, an education support resource for the Spanish-speaking community; Council for Bio-Medical Careers, an inner-city project to help blacks enter the health care field; and MOP, the Medical Opportunities Program, a scholarship fund at the University of Illinois for minority medical school students. The two former groups presented reports on their year's activities and asked for continued support. The Manpower Committee under this Council reviewed the activities of these groups and recommended grants of $9,000 for each to the Board of Trustees. The Board concurred. On-site visits to the two groups were required to assure appropriate application of the funds received.

Hamilton Teaching Award

Each year the Edwin S. Hamilton Interstate Teaching Award is presented to an outstanding Illinois medical educator. This Council nominates and elects the recipient for the Interstate Postgraduate Medical Association of North America. The Award, named in honor of ISMS past-president Edwin S. Hamilton, in 1973 will be given to Leslie C. Arey, M.D., professor emeritus of anatomy at Northwestern University Medical School.

Continuing Medical Education

One of the topics getting hotter each day is possible requirement for continuing medical education or re-examination for re-licensure or re-registration. It is understood that the Health Care Licensure Commission may recommend re-examination for re-licensure.

Several years ago, ISMS President Cannady suggested a statewide Council on Continuing Medical Education. This was continued by his successor, Dr. J. Ernest Breed. The outcome of this activity is the Illinois Council on Continuing Medical Education. Through this mechanism continuing medical education programs, an inventory of programs, evaluation of programs, delivery of programs, and coordination of activities between many groups active in CME can be accomplished. In addition, evaluation of the education being afforded and evaluation of the results of taking CME can be measured through various mechanisms. This is a pragmatic demonstration of the intention of the medical profession to keep itself abreast of current developments and deliver the best health care possible.

However, indications are that some form of mandatory CME is in the legislative offing. Based on this, the Council on Education and Manpower has, after lengthy, animated debate, formulated a resolution to be presented to the 1973 House of Delegates.

The intent of the resolution is to indicate that the medical profession is willing to accept responsibility for guaranteeing the continuing medical education of its members through its own mechanism, which would then be acceptable to meet any legislative mandates. The resolution speaks for itself. If further particulars are desired please contact the Council chairman. Hopefully all those interested in this important item will attend the reference committee hearing on this subject.

In this regard also, the Council has developed guidelines and principles for CME programs, approved by the AMA, which have been distributed throughout the state. These will be implemented through an agreement with the Illinois Council on Continuing Medical Education, as approved by the Board of Trustees. By this means, ISMS becomes the accrediting agency for intrastate CME programs.

Other Matters

Unionization of university faculties and the resultant spillover into medical school faculties, cuts in financial aid to medical institutions as proposed by the new secretary of HEW, state medical school budgets, the MECO program, extension of good samaritan legislation to paramedical personnel, curricula matters on sex education, alcoholism, and drug addiction, student loans and similar matters have been reviewed by the Council over the past year. This has taken many hours of committee, council and staff work. Hopefully, we have accomplished the charge to this Council.

ADVISORY COMMITTEE TO MEDICAL STUDENTS AND PHYSICIANS IN TRAINING

In 1972, the fourth year of its existence, the Medical Education-Community Orientation program (MECO) continued to attract increasing numbers of medical students, with 160 completing the program during the summer in 63 Illinois hospitals. For the first time, students from the Chicago College of Osteopathic Medicine took part in the program.

Applications for the 1973 summer program have been distributed to students and matching of students with the 129 openings in 55 hospitals is expected to be accomplished before the beginning of the ISMS annual meeting. As in every previous year, it is expected that interested students will far out-number the available openings.

Alan Roman, a sophomore at the Chicago Medical School, and Dr. Jerry Ingalls, a representative of the advisory committee, will supervise the matching process.

The Advisory Committee has been directed by the Council on Education and Manpower to undertake a productivity study of the MECO program to try to determine if exposing medical students to the private practice of medicine early in their educational careers does result in more doctors practicing in Illinois communities. This is expected to be an on-going evaluation.

Another attempt to interest students in living and working downstate is a pilot program in which physicians act as weekend hosts to medical students. A number of doctors have indicated willingness to participate in this program, but there has been difficulty in finding students able to accept the invitations .It is hoped that the ISMS offer to pay participating students travel expenses may heighten their interest.

In its attempt to implement **Resolution 72M-36,** the Advisory Committee has scheduled three meetings with interns and residents to improve communication and

develop liaison with them. Such meetings were held August 23 and September 20, 1972, with the third scheduled for January 10, 1973. Attempts to reach interns and residents have been made through hospital house staff organizations, national intern-resident organizations, and directly to intern and resident members of the Chicago Medical Society. Response to such invitations has been minimal and, therefore, the Advisory Committee has not been able to make any recommendations for implementing the three specific directives of the resolution: to set up regular meetings with high-ranking ISMS officers, develop a publicity campaign aimed at interns and residents, or to support "local issue conferences." The committee will continue to pursue the above objectives, however.

Although large numbers of medical students have not been involved in organized medicine, individuals have served on various ISMS committees and councils for several years and they have been attending AMA meetings as guests of the society. Bob Waxler, of the Chicago Medical School, and Michael Hughey, Loyola, attended all delegation activities as well as reference committee hearings and sessions of the House of Delegates in San Francisco, and Hughey attended the Cincinnati convention, too.

In accordance with the bylaws, the combined chapters of the Student American Medical Association, through their representatives on the Advisory Committee, elected Michael Hughey as delegate and Jeff Waitzman, University of Illinois, as alternate delegate to the 1973 House of Delegates.

Council

Jack L. Gibbs, *Chairman*

Morgan Meyer	Rex McMorris
Herschel L. Browns	John Holland
Lawrence L. Hirsch	L. P. Johnson
J. Ernest Breed	Donald Stehr
Allison Burdick, Jr.	Robert T. Fox, *Consultant*
Gerald M. Berkowitz	Fred Z. White, *Consultant*
Ross Hutchison	Allan L. Goslin, *Consultant*
George O. Dohrmahn	Jeff Waitzman, *SAMA*

Michael Hughey, *SAMA*

Advisory Committee to Students and Physicians-in-Training

Allison Burdick, Jr., *Chairman*

Lawrence Hirsch	Kenneth Furlong
Kenneth Campione	Jerry Ingals

Carl Barthelemy

Accreditation Subcommittee

Herschel Browns, *Chairman*	John Huss
Ross Hutchison	L. P. Johnson

Manpower Subcommittee

Morgan Meyer, *Chairman*

Rex O. McMorris	George Shropshear, *Consultant*
Donald Stehr	Allan Goslin, *Consultant*
Kermit Mehlinger	Mighael Hughey, *SAMA*

Student Visitation Programs Subcommittee

Gerald Berkowitz, *Chairman*

Allison Burdick, Jr.	Jeff Waitzman, *SAMA*
William R. Best	Armand Littman

EDUCATION & SCIENTIFIC FOUNDATION

The Educational and Scientific Foundation of ISMS was established in 1961. The Foundation is incorporated in Illinois and financial support is tax-deductible. It is dedicated to the advancement of medical knowledge and the education of the public, particularly in the State of Illinois.

A Board of Directors, that consists of the ISMS president, president-elect, immediate past president, secretary-treasurer and the chairman of the Board of Trustees manages the Foundation. The immediate past president serves as chairman of the foundation board and the secretary-treasurer of the society occupies the same post in the foundation. The classes of membership in the foundation are:

1. Fellows of the Foundation are physicians holding regular membership in the foundation following the contribution of $100 or more.

2. Associate fellows are non-physicians holding regular memberships in the foundation following a contribution of $100 or more.

3. Honorary fellows are individuals whom the foundation's Board of Directors elect to membership because of their exceptional service to the organization and its goals.

During the year, the foundation took the following actions:

A. Allocated from unmet medical needs:

1. $5,000 contribution to ASPIRA, with provision for a further contribution of $4,000 pending appropriate recommendation by ISMS.
2. $5,000 contribution to the Council on Bio-Medical Careers, with provision for a further contribution of $4,000 pending appropriate recommendation by ISMS.
3. A loan of $40,000 to the Illinois Foundation for Medical Care.

B. Agreed to pay 10 cents a mile travel expense to medical students participating in the Visitation Program sponsored by the Council on Education and Manpower.

C. Approved distribution of Chicago city maps provided by American Express. The maps are pocket size and wrapped in application blanks for American Express credit cards. American Express will pay the foundation $3 for each card issued from one of these appilcations.

The foundation received $3,000 from Merck Sharp & Dohme for operation of the Scientific Speakers Bureau in 1972. During the year, expenses and honoraria were paid to 32 physician-speakers addressing medical societies in the following counties: Bureau, Coles-Cumberland, DeKalb, Greene, Kendall, Knox, LaSalle, Livingston, Montgomery-Macoupin, Vermilion, Whiteside, Lee and Will-Grundy.

Charles J. Jannings, III, *Chairman*

Frank J. Jirka, Jr.	Jacob E. Reisch
William M. Lees	Willard C. Scrivner

Environmental and Community Health

COUNCIL ON ENVIRONMENTAL AND COMMUNITY HEALTH

In 1972, the Council on Environmental and Community Health was very active. In addition to maintaining liaison with the Illinois Department of Public Health and various voluntary health agencies, the Council has made several specific recommendations to the Board of Trustees.

The activities of the Council are presented in outline form as space does not permit complete detailing of all actions. Anyone desiring additional information on specific actions should address an inquiry to the council chairman or staff.

The Council:

1. Prepared a position statement relative to smallpox immunization and the need for continued programs, and informed the Illinois Department of Public Health of this action. Also, a resolution for the AMA was developed and accepted with modification.

2. Developed a brief school employee physical examination form to be recommended for use by all schools in Illinois. Current regulations require physicals only of bus drivers and food handlers, and by statute teachers must furnish evidence of good health, only at initial employment. This has been forwarded to the appropriate state agencies.

3. Recommended that all physicians be informed by newsletter and in the *IMJ* urging caution in nitroglycerin tablet packaging. In addition, physicians should caution patients against transferring tablets to other containers and never to place other tablets into the vial containing nitro tablets.

4. Endorsed legislation calling for minimum ambulance standards incorporating the recommendations of the Committee on Public Safety. **Resolution 72M-9** as passed by the House of Delegates, mandated ISMS support for such legislation.

5. Commissioned an article for *IMJ* on Multiphasic Health Testing and other materials on use of mechanical or electronic devices in patient care. This action follows the mandate of **Resolution 72M-12** passed by the House of Delegates.

6. Maintained liaison with the Chicago Alliance for VD Awareness, IDPH and the Chicago Board of Health by assisting in distributing educational materials. In addition, VD materials were mailed to the ISMS membership. This action accomplishes the intent of **Resolution 72M-14** as passed by the House.

7. Co-sponsored a conference on nutrition and school health with various state agencies.

8. Recommended that ISMS work with IDPH in developing a survey of private physicians performing clinical laboratory services in their offices.

9. Reviewed materials received from the Joint Committee on Health Problems urging health departments to budget more money for research to develop practical methods of prevention and detection of gonorrhea. The Council recommended Board endorsement of a resolution on gonorrhea and asking the delegation to the AMA to have it introduced in the 1972 Clinical meeting, which was accomplished.

10. Fulfilled the intent of **Resolution 72M-10** directing ISMS to inform its members that, until data is available proving the efficacy of Vitamin C for the prevention or cure of the common cold, the use of ascorbic acid for that purpose is not recommended. Notification to the membership was accomplished through the *IMJ*.

11. Recommended changes in the certificate currently being utilized for the pre-marital health examination. On this particular certificate a blood serology is called for and the certificate subsequently indicates that as a result of this test the physician believes the patient "to be free from all venereal diseases."

12. Urged support in principle for eight resolutions of the Mid-South Side Health Planning Organization dealing with Sickle Cell Disease. Related to this, the Council reviewed a resolution suggested by the Joint Committee on Health Problems of the NEA and the AMA. It was recommended that the resolution on sickle cell disease be endorsed and that the delegation to the AMA cause its introduction at the 1972 Clinical Conference, which was done.

13. Accomplished the intent of **Resolution 72M-11** endorsing the U.S. Bureau of Labor Statistics Low Standard Budget and recommending IDPA food allowances be increased to conform with the U.S. Department of Agriculture Medium Cost Plan. House action directed ISMS to inform IDPA of this action.

14. Recommended support for legislation amending the Communicable Disease Act by striking references to specific communicable diseases. This amendment would allow the Department to promulgate rules and regulation for immunization.

15. Opposed a proposed amendment to the Child Abuse Act that would change the present method of reporting suspected cases to include mandatory reporting to the police by the Department of Children and family Services before initial investigation.

16. Endorsed plans of the Illinois Society for the Prevention of Blindness to incorporate testing for diabetes melitus along with glaucoma screening in early 1973. This screening will be free to the public, as is the glaucoma testing.

17. Recommended opposition to the implementation of the Rubella Testing Act and the regulations issued by the Illinois Department of Public Health. The intent of the law is good; however, as written, the Act is defi-

cient. As the question of rubella testing is still pending in the courts, the Council is reluctant to make a further recommendation. The Council is still concerned with the advisability of requiring rubella testing as part of the marriage act.

18. Per the mandate of House action on **Resolution 72M-20**, the Council reviewed the report by Dr. Vlado Getting on public health conditions in Illinois. Specific recommendations will be reported in resolution form to the 1973 House of Delegates.

The Maternal Welfare Committee

The Maternal Welfare Committee of the Illinois State Medical Society has held three meetings during the past calendar year. Complete coding of the 1971 cases has been accomplished, and there have been a total of 55 maternal deaths discovered, which by definition included any woman dying of any cause whatsoever while pregnant or within 90 days of the termination of pregnancy, irrespective of the duration of the pregnancy at the time of the termination or the method by which it was terminated.

Of these 55 cases, it was impossible to assign the cause of death in one; 15 were thought to be due to nonrelated causes; 28 were thought to be direct; and 11 were indirect. The leading cause of death was infection, to which category eight cases were assigned, equally divided between post-abortal and post-partum infections. The implication that infection following abortion is apt to be much more serious than that following term delivery is obvious when one considers that the number of cases is equal; there are assumed to be considerably more term births than abortions.

Vascular accidents (emboli of various sorts) accounted for 6 deaths, attaining the second most prominent role for the first time in your chairman's memory. Hemorrhage and toxemia each accounted for five deaths. Anesthesia or complications thereof were considered to be responsible for two deaths. Pregnancy was indirectly associated with death in 11 cases, in which by far the most common cause was vascular disease, which accounted for five. Urinary tract and pulmonary disease account for two cases each, and cardiac disease and blood dyscrasia one.

Because of the time lag between death and review, only 15 cases of deaths occurring in 1972 have as yet been reviewed at the time of this writing. It is interesting that of these 15, 11 are considered to be obstetrical and four nonobstetrical, and in 12 preventable factors were thought to exist, attributable either to the patient, the physician, the hospital, or other causes. In some instances a combination of sources of preventability existed. In five cases, the patient's failure either to cooperate or exercise good judgment was thought to be involved. Areas in which there was a discussion of alternate or inadequate medical management occured in nine cases and the hospital was felt to be partially responsible in one.

We are grateful to those who have offered complimentary and/or critical constructive comments relative to the case history discussions which have appeared in the recent issues of the *Illinois Medical Journal*.

Your chairman would be remiss if he did not acknowledge the great help of the Illinois Department of Public Health, which contributes approximately $16,500 per annum to the program of investigation of maternal deaths.

In addition to analyzing, coding, and disseminating the causes of maternal death, your Committee is called upon to act as the investigating arm of the Society in areas which concern maternal care. During the past year, the Committee made recommendations relative to the use of oxytoxics and its commcnts relative to the need for revision of Section 15 of the Hospital Licensing Act were in part responsible for a revision of that act. Your chairman was honored to participate in the deliberations of that committee concerned with revision of this section. In addition, his position as chairman of this committee allowed him to be a party to the deliberation of the Illinois Public Health Department's Perinatal Co-ordinating Committee, which has as its purpose a discovery of methods of improving both maternal and neo-natal care.

In addition, your chairman and Dr. William Larsen, a committee member, were nominated by the Council on Environmental and Community Health to serve on the Ad Hoc Planning Committee to develop a comprehensive plan for perinatal care in Illionis. The advice of this committee has been sought on such matters as the new rubella testing requirement for marriage and the revisionary up-dating of a pamphlet entitled "Suggested Policies for Pregnant Women at their Place of Employment."

In conclusion, your chairman would like to again express his appreciation to the Committee members for their co-operation and advice. Their contributions to the deliberations of the committee are, without exception, sound and wise and cannot help but to have had a continuing beneficial influence upon maternal care in the State of Illinois. On behalf of the Committee, we would like to express our appreciation to the Board of Trustees for its continued confidence.

Council

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Maternal Welfare Committee

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ILLINOIS DEPARTMENT OF CHILDREN AND FAMILY SERVICES

The health related responsibilities and functions of the Department of Children and Family Services fall into these general categories: (1) provision of preventive and remedial health care for children who are wards of the Department; (2) implementing provisions of the Abused Child Act; (3) assurance of the health of children enrolled in the Department's residential schools for the visually, hearing, and orthopedically handicapped; (4) developing and assuring compliance with standards for health and safety in the child care facilities licensed by the Department; (5) provision of specialized habilitative and rehabilitative services for adult visually handicapped; and (6) assurance and/or provision of medical and nursing care for war veterans, and their wives or widows, in the Department-operated Illinois Soldiers' and Sailors' Home.

Department policies and regulations specify the standards and procedures for promoting and maintaining the physical and emotional health of the children and adults served by all of the Department's programs and facilities. These were prepared with and implemented under the guidance and advice of the Department's Public Health Officer.

Child Welfare

The Department provides direct child welfare services, meaning public social services which supplement or substitute for parental care and supervision for the purpose of: (1) preventing or remedying or assisting in the solution of problems which may result in the neglect, abuse or exploitation of children; (2) protecting and caring for homeless, dependent or neglected children; (3) protecting and promoting the welfare of children, including the strengthening of their own families and counseling of family members; (4) providing adequate care of children away from their homes, where needed, in foster family homes or day care or other child care facilities; (5) providing counseling for mentally retarded, physically, and socially handicapped children and their parents when not otherwise available.

Of the 27,000 children currently under care, some 23,000 are under the guardianship of the Department. These wards are provided preventive and remedial health care as well as medical treatment essential for the cure or amelioration of illness, disease, injury or pathology, and corrective and restorative dental treatment.

Preventive health care consists of periodic physical and dental examinations at prescribed intervals in the fields of pediatrics and dentistry. Complete physical examinations including all necessary laboratory procedures are provided or assured prior to placement. Routine physical examinations for children one to 21 years of age are provided annually, or more frequently if indicated by medical findings. For infants up to one year of age, usually the physician sees the baby monthly for the first six months and immunizations are administered as part of well-baby care.

Each child receives immunization against communicable diseases. Each child, three years of age and older, has a dental examination and prophylaxis, if indicated, every six months.

Most Department foster children are eligible for Department of Public Aid medical assistance through the MANG (Medical Assistance No-Grant) program. This includes payment for all services and procedures authorized by that program. As of February, 1972, preventive health care for children from birth through age five, who are eligible for service through the Department of Public Aid, is paid by the Medicaid program. The Department of Children and Family Services provides preventive health care services for children from age six through 20 without regard to eligibility for MANG, including routine physical and dental examinations and immunization. The effects and problems connected with MANG will be noted later.

The Department places children in facilities under its own supervision and purchases services from voluntary agencies and institutions. In the latter situation, the same policies and procedures for health care apply. When appropriate, maximum utilization is made of other public agencies such as the University of Illinois, Division of Services for Crippled Children.

The Abused Child Act, which became effective on July 1, 1965, requires practitioners in named medical professions and hospitals to report certain cases of suspected physical abuse, neglect, injury or malnutrition to the Department. In July, 1971, reporting of deaths of children from suspected abuse before they are found or brought to a hospital, was added to the Act. A Central Registry of cases is also required by the Act.

From July 1, 1965, through June 30, 1972, there were 4,258 cases in the Registry and of those, 233 involved deaths. Ninety-five children were dead on arrival. Department staff must investigate and offer services when a case is reported. A detailed study of the first year under the Act, July 1, 1965-June 30, 1966, revealed that in providing services, medical resources were frequently used, such as psychiatric, psychological, homemaker, and public health nursing.

Close working relationships between the Department and the various health professions and facilities are essential to the implementation of the Act.

Guardianship Administrator's Consent Required for Major Medical . . .

To protect all concerned, when *major* medical, dental, or surgical procedures are to be performed on wards (less than 18 years of age) of the Department of Children and Family Services, the consent of *only* the Department's Guardianship Administrator should be secured. *Social workers, foster parents and institution representatives have no authority to sign such consents.* The Guardianship Administrator has, by authority of law, designated four other Department executives in Springfield to act in his stead at such times as he may be unavailable. Thus, proper consents may be secured at any time, day or night, 365 days a year. For emergency consents the Guardianship Administrator or his authorized agent may be reached by telephoning 217-525-6533 during business hours, and 217-525-2367 (answering service) after business hours or on weekends and holidays. Consents that are telephoned or telegraphed will be followed automatically with written consents.

Written consents by the Guardianship Administrator will be provided in those cases of a non-emergent nature and which can be scheduled in advance. Requests for non-emergency consents should be channeled through the individual child's caseworker.

There are, of course, a variety of other programs and services in child welfare which do not involve the Department with health care to the same extent, nor in the same manner as above. For example, homemaker services may be provided to assist a family during a period of crisis to maintain the children and the family unit in their own home and; infrequently illness or a major illness or disability of the parent is not a basic reason for needing homemaker services. Family services other than homemaker to families rather than for a particular child or children in the family are provided in order to strengthen and maintain the family unit. Sometimes there are health problems for which the Department arranges the needed services.

In the program for unmarried mothers, which protects and promotes the welfare of mother and child, the Department provides counseling to assist in planning for the mother's future and in reaching decisions and plans for the infant, as well as arranging for medical care and providing maintenance as needed.

The most recent program, family planning, was initiated in April, 1971. This counseling is available to all families, unmarried parents, and wards for whom the Division of Child Welfare provides services. When the families or unmarried parents are unable to assume the medical costs of family planning (physician prescribed contraceptives), or such services are not otherwise available in the community, or the family is ineligible for MANG, the Department will pay the fees. Use of family planning services is voluntary and does not affect other services the Department may provide these families.

The Department licenses child care facilities under the Child Care Act. Standards developed in accordance with the Act include those which will insure the health and safety of children. The requirements are appropriate to the type of facility and include health standards applicable to the caretakers as well as the children served. The facilities include: foster family homes, adoptive homes, day care centers, foster family day care homes, children's institutions, child welfare agencies, and maternity centers.

Residential Schools for the Physically Handicapped

Illinois Braille and Sight Saving School and Illinois School for the Deaf, both in Jacksonville; and Illinois Children's Hospital-School, Chicago, require children to have physical examinations and immunizations prior to admission and at certain other specified times. Since these children are in residence, services and facilities are maintained to handle minor illnesses, injuries or other physical emergencies. Parents or guardians are responsible for medical, dental or any other health services except those that would be normally provided as a part of residential living.

Illinois Children's Hospital-School is exceptional since its purpose is the education of severely orthopedically handicapped children. Therefore, in or available to the school must be a comprehensive range of medical and related specialties. Although staff includes two full-time physicians, most of the physicians and dentists who care for the children are consultants regularly attending on either a fee or free basis. The physical facilities are specially designed for these children and include X-ray, dental, and laboratory equipment as part of the medical unit.

Illinois Soldiers' and Sailors' Home

With approximately 900 members on the rolls and the median age of 73+, it is quite apparent that the same trends that have effected the aging population generally are even more significant to the Home at Quincy. There are fewer whose needs are for domiciliary care and more, by far, than can be taken care of, needing long-term nursing care.

Among the requirements for admission is one that states that the applicant "is not mentally ill, or suffering from active or suspected tuberculosis, highly contagious diseases, or any condition that precludes being safely housed with aged or infirmed persons." Reasons for admission and continued stay in the Home mean that there must be a full range of medical and health services provided or available.

Complete care is provided in the medical units by five staff physicians, registered nurses, licensed practical nurses, and male and female medical attendants. A new 200-bed nursing care unit was completed and opened for occupancy in October, 1972.

Visually Handicapped Adults

Two programs for the adult visually handicapped have a minimal concern for the physical health of the individual served, but are directed toward the achievement and maintenance of individual social and emotional well-being. Community Services for the Visually Handicapped reaches individuals in their home communities through home teachers or counselors who provide a range of services individually or in groups. Included are such services as mobility training, homemaking skills, braille and other means of communication, and the like.

The Illinois Visually Handicapped Institute is a specialized rehabilitation center providing evaluation and training according to the needs of the individuals coming to the center. Social, psychological, medical, and occasionally, psychiatric examinations are part of the evaluation. If the people then go on into training, individualized programs are developed for them and the aforementioned services are available and used as appropriate in connection with the training.

In addition to utilizing general and special medical consultations, the physical well-being of the people at the Illinois Visually Handicapped Institute is emphasized through skillfully developed physical therapy, physical education, and physical recreational activities. This has been found to be particularly important to the improvement and maintenance of health of blind people. The program was further reinforced by the recent completion there of a four-year research project on "Postural Determinants in the Blind," conducted by an orthopedic specialist with a grant from the U. S. Department of Health, Education and Welfare.

Jimi Anne Lawrence

ILLINOIS DEPARTMENT OF PUBLIC HEALTH

The Illinois State Board of Health was organized July 12, 1877, with a working staff of three people—an executive secretary and two clerical workers. Its budget

was $5,000 plus $1,000 for contingencies.

Today, nearly a century later, the Department employs approximately 1,100 professional, administrative, technical and clerical workers who are engaged in a broad range of health services for Illinois' 11 million residents. Each year the Department administers state and federal funds in excess of 35 million dollars.

One reason for this growth is an increasing awareness of the value of public health and the increasing demands for its benefits. The Department assumes additional responsihilities as new health needs are recognized—needs that arise from a burgeoning population with complex health problems.

Bureau of General Administration: Administering a large organization is a great responsibility. The Department's affairs are kept in order by the Bureau of General Administration. As the general service unit of the Department, the Bureau provides managerial and professional services which are necessary to divisions concerned with specific public health programs. To perform its responsibilities of supportive services, management and coordination, the Bureau is composed of six divisions: Administration, Budget and Fiscal Operations, Electronic Data Processing, Education and Information, Local Health Administration and Public Health Laboratory.

Bureau of Personal and Community Health: The Bureau of Personal and Community Health is charged with the responsibility of administering the health care and disease control programs of the Department of Public Health. Programs within its jurisdiction include both those designed to prevent illness and disability and those for assuring quality health care. To accomplish these functions, the Bureau is divided into six divisions: Dental Health, Disease Control, Emergency Medical Services and Highway Safety, Family Health, Health Facilities and Nursing.

Bureau of Environmental Health: The Bureau of Environmental Health is responsible for programs in which evaluation and control of environmental conditions is necessary to protect the health and lives of Illinois citizens.

Inspection and consultation for program effectiveness are conducted through the seven branch offices, each of which has technical staff members acting as bureau representatives. The field of environmental health is becoming increasingly complex with the public expecting assurance that their health and well-being is protected. The Bureau provides this assurance with programs in the following divisions: Food and Drugs, Milk Control, General Sanitation, Radiological Health, and Swimming Pools and Recreation.

A new recreation camp law, a youth camp law, a mass gatherings law and amendments to the current trailer park and migrant labor camp laws, in general, authorize the Department to prepare rules and regulations for sanitary controls to protect the health of the citizens of the State of Illinois.

Chicago Hospital and Clinics: Effective July, 1971, the Department of Public Health has operated the former Chicago State Tuberculosis Sanitarium as a "flexi" general hospital. This modern 400-bed facility has become a demonstration area for special projects in screening and health care delivery.

Today, less than a year later, the Chicago Hospital and Clinics operates an efficient Geriatric Transfer Program, supports an Illinois Drug Abuse Program—methadone maintenance clinic and the Central Intake Unit for the program—and provides medical services for a Department of Public Aid Medical Evaluation Program.

A 52-bed inpatient geriatric unit with an average daily census of 45 patients is on the hospital's fifth floor. There geriatric patients, some of whom had previously been admitted or confined unnecessarily in mental hospitals, are screened and placed in appropriate facilities. The only criteria for admission to the geriatric program is to be 65 years of age or older.

Plans call for a 50-bed unit for alcohol and drug abuse inpatient program, a family planning clinic and training center for the state and an Illinois Department of Public Health regional office.

Mt. Vernon State Tuberculosis Sanitarium: Because modern technological developments in medicine have caused a dramatic decline in the number of hospitalized tuberculosis patients . . . and because the health needs of the public now encompass broader areas of services than they did a decade ago, a portion of the Mt. Vernon facility was allocated to the Department of Mental Health for the care of severely and profoundly retarded individuals. Although the facility is still controlled and administered by the Department of Public Health, cooperation was pledged to provide space for the program for the mentally retarded while still retaining sufficient beds and facilities for the care of the tuberculosis patients.

Advisory Boards to the IDPH

- **Board of Public Health Advisors**
- **Advisory Board for Clinical Laboratories and Blood Banks**
- **Advisory Hospital Council**
- **Hospital Licensing Board**
- **Immunization Advisory Committee**
- **Migrant Labor Advisory Committee**
- **Advisory Board of Necropsy Service to Coroners**
- **Long Term Care Facilities Advisory Council**
- **Radiation Protection Advisory Council**
- **Renal Advisory Board**
- **Ohio River Valley Water Sanitation Commission**
- **Tuberculosis Advisory Committee**
- **Laser Advisory Committee**
- **Advisory Committee for the Child Hearing Test**
- **Hazardous Substance Advisory Council**
- **Plumbing Code Advisory Council**
- **Recreational Area Advisory Council**
- **Committee for Revision of Rules and Regulations for the Control of Communicable Disease**
- **Advisory Committee for Heritable Metabolic Diseases**
- **Advisory Committee on Prevention of Accidental Poisoning in Children**
- **Advisory Committee on Pediatric Lead Poisoning**
- **Advisory Committee to the Program for Care of Premature and High Risk Infants**
- **Youth Camp Advisory Council**
- **Advisory Committee for Critically Injured Patients**
- **Grade A Milk Advisory Board**

Conclusion

The Illinois Department of Public Health is a multifaceted organization designed to serve the public health needs of all the people in the state.

We welcome your requests for more detailed information about the Department or suggestions for any of its programs.

Franklin D. Yoder, M.D., M.P.H., *Director*

Finances and Budgets

REPORT OF THE SECRETARY-TREASURER

In order for any organizations to function and progress effectively, there must be some method of direction and policy determination to guide the executive and administrative segments of the organization. Historically, as the concept of democracy and direct representation have become widely accepted, such basic responsibilities have come from the individual components of the oganization. In the instances of societies or associations these are usually the members, or, in present day more descriptive phraseology, the "grass roots."

Such is the "government" of the Illinois State Medical Society. At least once each year a democratic body, consisting of elected representatives of the membership, collectively designated the House of Delegates of the Illinois State Medical Society, assembles to examine and discuss current material issues relevant to their common benefit, review the successes or failures of their past decisions and make plans for the forthcoming year. The resultant conclusions of these deliberations, arrived at by majority opinion, become the policy of the Society.

In 1972 the ISMS House of Delegates met on March 7-11. There was no interim meeting during the year. To insure accuracy of the actions of the March House of Delegates meeting, a complete stenographic record of each House session was recorded and transcribed. In my capacity as Secretary-Treasurer of the Society, I have audited the 1972 transcript and found it to be accurate and complete. It consists of 342 pages. It has been retained and is filed in the archives of the Society for reference and historical purposes. Any member who may wish to review the transcript may do so upon request to the Secretary-Treasurer or the Executive Administrator.

The component societies, delegates and members were informed of the 1972 House's actions and decisions by the prompt preparation of an edited version of the transcript which detailed all major actions. This was distributed shortly after the meeting and, in addition, the May, 1972, issue of the *Illinois Medical Journal* carried an abstract of the transcript.

As has been the custom in the past, the abstract form of the 1972 transcript will be presented to the 1973 House of Delegates for approval as the official minutes of that meeting.

Membership

Membership statistics for the past six years are listed in the accompanying table. As indicated in this table total membership increased for the fifth consecutive year while regular membership has decreased slightly in the past two years. Early 1973 dues collections indicate a reversal of this decrease in regular membership.

1972 Financial Results

The preliminary (unaudited) December 31, 1972, year-end financial report of ISMS with 1972 and 1973 budgets will be mailed to each delegate by February 19, 1973. This will enable Delegates to review the Society's financial position, results of operations, and future planning prior to Reference Committee hearings. It should be noted that the detailed final audit report prepared by Peat, Marwick, Mitchell & Company will not be available in time for the House Assembly, but will be mailed to each member of the House upon completion.

Permanent Reserve & Benevolent Trust Fund Investment Analysis

The accompanying tables presented to your Finance Committee as prepared by the brokerage firm, A. G. Becker & Company, list statistically the performance of Continental Illinois Bank, as trustee of your funds, in comparison with other similar funds. We call your attention to the fact that ISMS ranked in the top 25% of total fund return over the cumulative nine year period.

Annual Performance Summary

	Total Fund Return	Equity Commitment	Equity Return	Fixed Income Return
Maximum	29.31%		39.50%	30.41%
First Quartile	19.26	82.2%	28.88	14.12
Median	15.92	73.1	17.43	12.33
Third Quartile	13.62	63.2	14.71	9.36
Minimum	5.35		3.02	-1.54
ISMS Fund	19.29%	77.4%	24.62%	8.74%
ISMS Rank	13	20	8	39
Number of Funds	50	49	49	47

Finances

In last year's annual report I advised the House that the Society's 1972 operation would be "in the red." This proved to be true. Based on unaudited and preliminary figures, the ISMS 1972 expenditures were $969,615, while the income was only $926,984—a deficit of $42,631. However, we did not overspend. The final 1972 budget authorized and appoved by the Board of Trustees was $907,800, so $1,235 less than allocated was spent. Of even greater interest is that the 1972 expenditures were $37,466 less than in 1971. The explanation for the seeming incongruity of these figures lies primarily in our income, which was down by over $9,000. The $970,800 on which we based the budget just was not met. Principle items were *Illinois Medical Journal* advertising, $13,000 less than anticipated and membership dues, $3,000 less than projected.

Membership Statistics

Changes in ISMS membership statistics for the past several years, as recorded in the Society's records, are indicated in the accompanying table.

	1972	*1971*	*1970*	*1969*	*1968*	*1967*
Membership as of January 1	10,798	10,692	10,650	10,627	10,568	10,607
New Members	509	426	354	370	425	515
Reinstatements	43	27	28	46	40	43
Total added	552	453	382	416	465	558
Dropped during the year:						
Died	173	146	145	190	205	211
Moved from State	57	49	73	66	50	151
Resigned	43	37	12	13	6	12
Nonpayment	157	121	110	124	145	223
Total dropped	430	353	340	393	406	597
Membership as of December 31	10,914	10,792	10,692	10,650	10,627	10,568
Regular	9,323	9,399	9,405	9,389	9,375	9,335
Residents	406	276	207	223	196	214
Service	52	63	126	101	105	59
Emeritus	568	514	463	472	507	514
Retired	519	484	456	434	403	399
Hardship	46	56	35	31	41	47
Intern						
Total	10,914	10,792	10,692	10,650	10,627	10,568

The prognosis for 1973 is more favorable. We anticipate a balanced budget this year—the first since 1970. This, of course, is due to the $25 dues increase approved by the House last year.

An early peek at the 1973 operation discloses a probable budget of over one million dollars—the first in the Society's 133 year history. A preliminary estimate is about $1,028,325.

Where a dues increase was requested from the House last year, the delegates were assured that according to our best estimates such additional income would be sufficient to "carry" the Society for the next five years. In an effort to keep that promise, and ensure solvency for the Society, we have developed a five-year plan of allocations.

First, we'll wipe out the $56,170 deficit incurred in operating expenses during the past two years. Second, we'll build up the Benevolence Fund by allocating $9,350 to it ($1 per dues paying member) for each of the next three years. This will be in addition to the $46,750, or $5 per member, we allocate annually to this fund. Third, we'll build up our permanent reserves by allocating $51,405 this year, $55,175 next year and $12,375 in 1975. (Note that the permanent reserves are "plugged" with large contributions in the early years to take advantage of investment income.) We also plan a $9,350 allocation to the Contingency Reserves this year; $20,575 next year and another $20,575 the following year. In 1976 we'll withdraw $2,100 for use as operating funds and withdraw the remainder in 1977. This, with prudence and careful planning, is the best way we have of assuring solvency of the ISMS for the next five years.

Cumulative Performance Summary
1963 Through 1971

	Total Fund Return	Equity Return	Fixed Income Return
Maximum	9.43%	12.19%	6.33%
First Quartile	6.75	9.18	4.26
Median	5.97	8.71	3.30
Third Quartile	5.04	7.75	2.66
Minimum	3.05	5.87	1.44
ISMS Fund	6.96%	9.23%	3.69%
ISMS Rank	6	6	8
Number of Funds	24	24	19

Now comes the usual admonition and words of caution. After all the above allocations and deductions have been made, the increased amount left for operating for 1973 is only $58,710—approximately 6%—more than we spent last year. With the usual cost of doing business expected to "eat" at least half of this, it readily becomes apparent that there are no funds for any new *major* programs or projects in the coming year. Consequently, should the House envision and direct any new major activities for 1973 necessitating additional expenditures, a fiscal note must accompany the recommendation as to the source of the increased income to finance it. This will become readily apparent when the 1973 budget is examined. In addition, a proposed 1974 budget will be

provided each member of the House prior to the 1973 meeting.

It is also noted that during the past year, while there have been replacements and reassignments of staff personnel, there has been an overall increase in staff size despite the additional work loads and projects undertaken.

Leadership Conference

The 1972 Leadership Conference was held October 29 at the Regency Hyatt House in Chicago. This year's conference was devoted entirely to indepth considerations and discussions of professional liability.

The Society's Leadership Conferences, usually held annually, each fall, are the Society's second largest meeting each year, being surpassed only by the annual convention. These intense one-day meetings on matters of urgent or current concern provide not only the opportunity for members to learn about socio-economic problems "as they are happening," but also to express their opinion on such subjects and thereby give the Society some degree of guidance in its decisions.

The morning session dealt with an evaluation of the extent of the malpractice problem in Illinois, the increasing degree of hospital liability, an explanation of the reasons for the ever-increasing premium rates and a look into the future as to possible legislative regulations.

During the afternoon a possible new form for the settling of claims—*arbitration*—was described and weighed for benefits and objections. ISMS is to explore the possibilities and workings of arbitration further, the Board of Trustees having authorized a pilot program during 1973.

At the luncheon, a citation was presented by the National Selective Service System to Dr. Carl Steinhoff for his 22 years of service as Chairman of the Illinois Medical Advisory Committee. In addition, ISMS 1972 contributions were presented to ASPIRA and Bio-Medical Careers for their excellent work in the health career fields.

1972 Illinois State Fair Exhibit

The 1972 ISMS Illinois State Fair Booth in Springfield featured an exhibit on one of today's major public health problems, venereal disease. The colorful and attention-getting display, equalling the success of health exhibits of past years, attracted an estimated 30,000 people during the Fair's 10-day duration.

ISMS has presented an informational and health-oriented exhibit at the Illinois State Fair annually for almost 20 years. It is the only project in which the Society has a direct contact with the public and serves as tangible evidence of the interest of Illinois physicians in the over-all health of Illinois residents. Here the Illinois State Medical Society becomes more than just a name to a large segment of both urban and rural population.

In addition to posters and other displays calling attention to this rapidly increasing hazard, a series of color slides on VD effectively combined a dramatic illustration of the dangers of the disease with a plea for early treatment. Many of the slides, presented continuously for 12 hours each day, were specially prepared by ISMS and were quite specific and direct in telling the unhappy VD story. They were designed for maximum impact on the teenage group and were quite effective in attracting their attention.

Over 40,000 pieces of literature, including the Society's Health Information Card and VD pamphlet, were distributed. ISMS is indebted to the Illinois Department of Public Health for providing quantities of four informational booklets.

The ISMS Venereal Disease pamphlet, which was extremely well received last year, was the most widely distributed brochure again in 1972. Teachers and others in the educational field requested quantities for distribution in schools. Similar requests were received for several weeks following the Fair.

This year ISMS shared its booth with the State Comprehensive Health Planning Agency which presented a display outlining its activities.

Condolence Letters

ISMS has continued to send an individually typed and personally signed letter of condolence, properly worded to fit the occasion, to the families of all deceased members. Many gracious and appreciative replies have been received from these expressions of sympathy.

Other routine personalized and individually signed correspondence has been sent to each member elected to emeritus, retired or cancellation of dues status.

Benevolence

A change in the 1972 By-Laws placed the responsibility of administering the Society benevolence program with the Finance Committee.

During 1972, the policies of the Society's benevolence have continued as developed in past years. Allocation to recipients has been made essentially the same as in 1971, except for isolated cases of emergency and hardship where an additional allowance was provided.

The year started carrying 30 recipients, of which three were physicians and 27 widows of physicians. During the year four widows and one physician were removed from the list; three widows were added resulting in a total of 28 recipients of benevolence payments at year end. The monhtly average for 1972 in total actual cash payments was $5193.00.

The investments of the Benevolence Fund are made and managed (with approval of the Finance Committee) by the Trust Department of the Continental Illinois National Bank and Trust Company. It is to be noted that the Benevolence Funds are "pure"; every dollar allocated by the Society or monies donated to the Fund are used for benevolence. The By-Laws specify that all custodial or administrative expenses concerning benevolence be borne by the Society.

The Society is again grateful for the assistance of the Woman's Auxiliary whose contributions to the fund in 1972 amounted to approximately 9% of the total assistance payments.

Additional contributions are sought for this fund and will be added directly to the principal. It is the Society's desire to increase the fund to the point where the return on investments will provide the amount needed for the annual benefits needed.

All applicants will be reviewed again and evaluated early in 1973 for need and eligibility and recommendations for the year made to the Board for approval.

SOCIETY SERVICES AND BENEFITS

Often the question is asked: "Why should I belong to the Illinois State Medical Society?" or "What does the Illinois State Medical Society do for me?"

Obviously, the Illinois State Medical Society cannot reach out, touch the shoulder of every member, and ask: "What can I do for you today?" By no stretch of the imagination does the Society have such extensive or personalized capabilities or powers. It is questionable if such would even be desirable—or effective from an organizational standpoint. Yet, in many instances, the Society does accomplish essentially individual services in a collective way. In the listing of some of the many major involvements and achievements of the Society during 1972, consider how many of them actually do benefit and help each physician individually and personally. And possibly more important, how many of these endeavors could not have been achieved other than from an organizational standpoint. It is not only unity but numbers also that command strength.

While all activities cannot be listed because of space limitations, a synopsis follows outlining what the Illinois State Medical Society did in 1972:

- Persuaded the Illinois Department of Public Aid to develop a simplified Medicaid billing form (which will be available during early 1973), thereby reducing physicians' paper work and expediting payments.

- Stopped Aetna Life and Casualty Company from offering legal assistance to patients sued by physicians for unpaid or partially paid bills. (However, Aetna is still bound by contracts to take such action in some of its group insurance coverage.)

- Developed a "Statement of Understanding" for use by ISMS members to remind patients that they alone are responsible for physicians' charges. The statement, distributed to the full membership, points out that physicians are *not* bound by patients' contracts with third parties.

- Obtained decreases in proposed premium increases in the ISMS-sponsored professional liability insurance program. ISMS not only negotiated with the carrier, insurance broker and lodged protects with the Illinois insurance commissioner, President Nixon and the Governor, but also sent a Society officer direct to the U.S. Price Commission to protest. This resulted in obtaining a sizable percentage reduction of the premium increase.

- Planned a pilot program, to start in 1973, to settle malpractice claims by arbitration rather than by court action. Authorities believe that arbitration procedure, when properly adapted to the specifics of medicine and given a fair opportunity to be understood and accepted as an equitable and impartial procedure, can encourage fair decisions, minimize the submission of frivolous claims, eliminate publicity, speed up settlements and possibly reduce the amounts of judgments.

In its legislative program, ISMS:

- Supported a bill requiring labels on all blood for transfusions, indicating whether it was purchased or donated. It is hoped that the bill, which offers incentives to volunteers, will encourage more blood donations and thus stop the increasing rise in hepatitis resulting from blood purchased from questionable sources.

- Protected physicians' licenses by supporting a bill keeping the licensure and registration of physicians exclusively a State function.

- Blocked legislation calling for mandatory eye examinations for school children which the Illinois Association of Ophthalmologists termed "unnecessary" due to existent eye screening programs. The bill would have allowed optometrists, but prohibited family physicians, from performing the exams.

- Established a more thorough system for the review of the more than 300 health care bills to be considered by the 78th General Assembly in 1973. Among these are:
 - Licensure or certification of physician's assistants.
 - Revamping of the coroner system.
 - Substitution at the discretion of a pharmacist, of medicine or drugs specified in a physician's prescription.
 - "Certificate of Need" (a determination of hospital or long-term health care facilities and their development).

During the year more than 30 councils and committees made up of physicians and ISMS staff worked on many studies and follow-up activities which led, or may lead, to the benefit of physicians and their patients. Noteworthy of mention are: fees and fee adjudication; health care cost and utilization; new modes of health care delivery; health care planning programs; intensified medical education for physicians and paramedical personnel; programs related to health care facilities; hospital costs and services, and rural health and health care for the poor.

There are still many more avenues of involvement and types of activities. In addition, ISMS:

- Published the "Reference Issue" of the *Illinois Medical Journal* to inform the membership of statewide services available; to indicate areas of ISMS activity and the members developing such activities and to categorize State of Illinois medical organization and medical education services. All of this constituted a compendium of over 150 pages of up-to-date ready reference information.

- Provided many staff services to the Auxiliary and assisted with their communication to their membership. Space in ISMS publications was also allocated as well as mailing lists and labels.

- Served, through an ISMS Peer Review Committee, as the appellate body for all county and district Peer Review Committees, in a concerted effort to maintain high standards for medical care throughout Illinois.

- Provided benevolence to members and their survivors in their later years when unkind economic toll has necessitated financial assistance. This unheralded activity of the Society is basic to the tenets to which the medical profession is dedicated and upon which the Society was founded.

- Recognized and honored its member physicians who have practiced 50 years with a luncheon at its annual meeting and provided each with a personalized certificate of membership in their select group. Illinois was the first state to establish such recognition.

- Sponsored a "Job Fair" wherein Illinois communities needing a physician and physicians seeking locations to practice were brought together for direct discussion. The 1972 fair had 63 community participants and over 318 physicians desiring practice opportunities in attendance.

- Served as a clearing house of information on medicine, health, licensure, education, postgraduate programs and other similar matters.

• Provided cooperative advice and guidance to several voluntary health agencies.

• Maintained a scientific "Speakers Bureau" for county or branch societies, or professional groups, in an effort to conitnue the upgrading of medical knowledge.

• Sponsored various insurance plans, including malpractice, and maintained liaison with carriers. In addition, served as a hearing body and liaison agent for insurance misunderstandings and complaints of the sponsored plans.

• Cooperated with the Board of Medical Examiners of the Department of Registration and Education, as well as assisting incoming physicians to Illinois in expediting their obtaining a license.

• Maintained liaison with hospital associations and held numerous joint meetings on problems of mutual concern.

• Provided personal visits of Society president, other officers and staff members at county society meetings upon request.

• Assisted component societies with special and direct public relations programs.

• Provided full dues collection services, without cost, for component societies desiring it.

• Gave, on numerous occasions, the medical profession's views to state officials and governmental agencies.

• Held Public Affairs programs which provided information on candidates for public office.

• Provided extensive news releases to all print and broadcast media, newspapers, magazines, radio, TV, to keep the public abreast of medicine's position on important issues and the promotion of good personal health policies.

• Cooperated with medical schools and their deans in developing innovative programs of health education and training.

• Sponsored, with the Illinois Agricultural Association, a Student Loan Fund. This program has been in existence more than 20 years.

• Developed ways and means of involving medical students in Society affairs and Illinois medicine in an effort to retain them for practice in Illinois.

• Maintained, as in the past, an Impartial Medical Testimony Panel for Illinois and U.S. courts.

• Cooperated in many ways with AMA projects and programs.

• Provided literature and reference material on selected topics to schools and students.

• Furnished information on internships and residencies.

• And, in an attempt to provide more than only professional and scientific needs, sponsored membership tours to foreign areas at special reduced rates. During 1972 these included such places as the South Pacific, Mediterranean, Africa and the Orient.

Conclusion

ISMS has again experienced another fruitful year, despite obstacles and problems. The Society's officers and staff have had to face an ever-increasing pattern of challenges to the profession's rights and freedom. Legislative domination and control slowly but surely increases. Alertness and prompt action in combatting some of the trends have been successfully handled, thanks to the ability and foresight of an excellent staff. They have proved their worth and merit our sincere thanks and commendation.

Jacob E. Reisch

Governmental Affairs

GOVERNMENTAL AFFAIRS COUNCIL

The past two years of the 77th General Assembly and its legislative actions became history on January 10, 1973, when the 78th General Assembly convened as a new body.

The physicians of Illinois can take real pride in the legislative activities of the State Medical Society over the past two years. If nothing else, the track record of physician involvement within the legislative arena enhanced the effectiveness and common goal of medicine—a sounder, more effective health care delivery system for the people of Illinois.

The following analysis is a report of the legislative activities of your Governmental Affairs Council. The report itself is broken into four sections—legislation initiated by ISMS; legislation supported by ISMS; legislation that we sought to amend; and legislation that we opposed.

ISMS Legislation

Exemption for AMA/ERF Loans: The Illinois General Assembly has again extended the expiration date for medical student loans under the American Medical Association/Educational Research Foundation (AMA/ERF) program. The Legislature amended the Illinois Usury Law on July 1, 1970, to exempt loans under the AMA/ERF program from the Usury Law limitation (8 percent) in Illinois until December 31, 1972.

Since 1962, 1,676 loans totaling $1,754,544 have been made to students attending medical schools in Illinois under this program. The loans are, in effect, unsecured installment loans which would under ordinary circumstances not be available to the borrower and would carry "add on" interest rate of 6% or more, which equals 11% or more in simple interest.

House Bill 4427, signed by the Governor on August 8, 1972, extends this exemption to medical student loans until Jan. 1, 1978. The passage of this bill will assist many financially needy students in attaining their goal of practicing medicine, and thus will help alleviate the physician shortage.

Exoneration from Liability: Legislation was introduced into the 77th General Assembly calling for an amendment to the medical practice act to exonerate from civil liability, the members of any committee under the Hospital Admissions and Surveillance Program of the Illinois Foundation for Medical Care (HASP) for their acts or omissions. If this bill had received passage it would have granted or exonerated from liability members of all HASP Committees, whether they be at the state level, regional level or local level. While the bill was defeated in the Senate Judiciary Committee, your council has been instructed to seek new legislation for the year of 1973.

Legislation ISMS Supported

Licensing and Registration Exclusively a State Function: On April 28 the Governor signed into law House Bill 3636, which declares that the licensing and registration of 30 different professions (physicians, dentists, nurses, etc.) vocations and occupations is exclusively a state function and prohibits the licensing of these professions by home rule units.

The new Illinois Constitution declared that, "a home rule unit shall have only the power that the general assembly may provide by law," and one of these powers is "to license for revenue or impose taxes upon or measure by income or earnings or upon occupations." Although the home rule unit was prohibited by the Constitution from licensing for revenue, unless that power was granted by the General Assembly, it may have only been a matter of semantics. A home rule unit may have decided that it should produce a directory of physicians for reference use. To do so, it would need the home and office address of each physician within that municipality. Using this type of an end-run tactic, the home rule unit could have charged a fee for licensing just to cover the administrative cost of producing such a directory, as well as maintaining the administrative personnel cost. Any revenue not used by these personnel would have been returned to the general fund.

The Illinois State Medical Society joined various other professions in the state to coordinate all legislative efforts for the passage of this bill. Many Illinois physicians made contact with their respective legislators with reference to this bill and were the effective force needed to win this battle.

State Hospitals and Permit Physicians: Inspired by general public reactions to the medical care being given to patients in state operated hospitals, the General Assembly took swift action and passed Senate Bill 1530. This act, had traveled a rocky road from its inception on April 26, 1972, through June 6 of this year. At one time the bill was tabled; then was brought back to the House floor for further consideration and subsequently was passed.

Under this bill the Medical Practice Act will be amended to provide that state hospital permits of physicians not otherwise licensed to practice may be renewed only twice after July 1, 1973, for one year periods each, with all original permits and renewals to expire on the July 1 after issuance. After July 1, 1974, all permit holders seeking renewal will be required to pass a new examination to be given by the Department of Registration and Education or an equivalent examination.

State Mental Institutions to Meet Minimum Requirements: An act (House Bill 3602) which has passed both houses of the General Assembly, calls upon the Illinois

Department of Mental Health to report before Feb. 15 (a change in date from the prior reporting date of Dec. 15) of each year to both the Governor and the General Assembly.

The Department will make its annual report based on a list of all state institutions indicating those which meet the minimum requirements imposed by state laws and regulations on private facilities providing comparable services and those which do not meet such standards. The report also indicates those that do not meet the *minimum* standards, the areas of deficiency and recommendations for compliance. Institutions or parts thereof which have not been fully accredited by the federal government shall also be reported together with the reasons for nonaccreditation.

Licensing of Ambulances and Services: ISMS supported a bill which established and called for the upgrading of the present ambulance services in Illinois. While we basically support this measure, consideration was also raised as to the potential destruction of present ambulance services by requiring that all operators meet the minimum standards as set forth in the Federal guidelines. This action would have meant that all ambulance services must conform to both the equipment and personnel requirements. The main issue involved is the cost of compliance. This ambulance bill was defeated; but, we expect another bill in the new 78th session.

Lead Poisoning Controlled Substances Act: Legislation mandating all county health departments to establish and maintain a program to examine and inspect all dwellings which are suspected of containing lead base paint on the interiors and exteriors .This controversial measure was defeated. The same bill has been re-introduced in the 78th General Assembly.

Illinois Health Facilities Authority Established: With passage this session of the Illinois Health Facilities Authority Act (HB 493), the legislature took a major step in providing financing for non-profit health entities (hospitals, etc.).

The seven member Authority Board, appointed by the Governor with the advice and consent of the Senate, will have the power to enter into contracts, issue bonds, charge rentals or fees for services or facilities furnished, and establish rules and regulations regarding the use of these services or facilities. The Authority may lease projects to institutions and transfer the project to the institution upon repayment of the indebtedness. This law additionally requires that any plans involving the making of loans or the issuing of bonds be submitted to the Comprehensive Health Planning Agency for review and comment.

Amended Legislation

Legalize Paramedics: The Emergency Medical Treatment Act was amended to permit establishment of hospital pilot programs in which mobile intensive care personnel (paramedics), under the supervision of a physician, could provide emergency medical care at the scene of an accident, enroute to a hospital, and until care can be assumed by the regular hospital staff. The Amendment (SB 1571) additionally exempts from civil liability the physician or nurse who in good faith gives emergency instructions to mobile intensive care personnel at the scene of an emergency. This law also exempts the "paramedic" who follows the instructions. The Department of Public Health must approve these hospital based pilot programs. In 1973, the Department is mandated to report to the General Assembly on the effectiveness of the program.

The law also specifically delineates what the mobile intensive care personnel can do:

1. Render rescue, first-aid and resuscitation services.
2. Perform cardiopulmonary resuscitation and defibrillation in a pulseless, nonbreathing patient.
3. Where voice contact is maintained and a telemetered electro-cardiogram is monitored by a licensed physician or a registered professional nurse (who has completed training course approved by the Department and is authorized by the physician), the personnel may do any of the following upon order of the physician or nurse:
 a. Administer intravenous saline or glucose solutions.
 b. Perform gastric suction by intubation.
 c. Administer parenteral injections of any of the following classes of drugs and their appropriate antidotes: Antiarrhythmic agents; Vagolytic agents; Chronotropic agents; Analgesic agents; Alkalinizing agents; and Vasopressor agents.
4. During training administer parenteral medications under the direct supervision of a licensed physician or registered professional nurse.

The Illinois State Medical Society is working with the Illinois Department of Public Health to promulgate the rules and regulations implementing the law.

New Action on Blood—Purchased or Donated: In 1971, the Illinois General Assembly enacted into law H.B. 16, which relieved blood donors, physicians, hospitals, and blood banks from liability in giving blood transfusions. This law was drafted pursuant to the Illinois Supreme Court decision on the Cunningham *vs.* McNeal Memorial Hospital suit. H.B. 16 has an expiration date of July 1, 1973. As of that date, those involved with blood, whether it be donor, physician, hospital or blood bank, will no longer receive immunity.

House Bill 4445, which has been signed by the Governor, is aimed at creating a uniform voluntary blood donor system in Illinois. In accomplishing this, any individual, blood bank, hospital, firm, corporation or any other entity must comply with the criteria for donor selection to be promulgated by the Illinois Department of Public Health.

In addition, any person who withdraws blood from an individual or separates blood into components shall affix to each container of such blood or components a label in a form specified by the IDPH which includes an indication of whether the blood was obtained by purchase or donation. When blood is administered by transfusion in this state, the identification number of the unit of blood will be recorded in the patient's medical record, and the label on the container may not be removed before or during the administration of the blood.

After July 1, 1973, no blood initially acquired by purchase may be administered by transfusion in Illinois unless the physician in charge of the treatment of the patient has directed that such purchased blood be administered to that patient and has specified in his medical record the reasons for such action.

Legislation Opposed by ISMS

Mandatory School Eye-Screening by Optometrists and Ophthalmologists Defeated: After a two year battle in the Illinois General Assembly, House Bill 2033 has been defeated. House Bill 2033 would have required

that eye screening examinations for school children entering kindergarten, first, fifth and ninth grades must be performed by ophthalmologist or licensed optometrist and reported on separate forms.

This legislation would have prohibited school nurses, pediatricians, general practitioners, internists and eye screening technicians from giving the eye screening tests at the local school district level, as mandated by the passage of House Bill 2113 during 1971. As a preemptive piece of legislation, this bill would have abolished the present vision screening program as part of the regular school physical examination. This would have entailed an additional cost to parents of more than seven million dollars a year and added to the Public Aid Department's budget by more than one million dollars annually.

Each year more and more children are entering school for their first time or at least in their respective grade levels. Taking this total figure into account and dividing it by the total number of optometrists and ophthalmologists in the state, would mean an increase in the number of patients to be seen (for just eye screening exams) by an additional 270 new patients per year. There now exists in Illinois a shortage of ophthalmologists and optometrists, especially in the downstate areas. This proposal only would have aggravated the situation,

Coroners: During the spring session of the General Assembly, an unsuccessful attempt was made by the Illinois Coroners Association to establish a new system of medical legal investigation, while retaining the present archaic system of investigation. Many counties in Illinois already have eliminated the office by public referendum. The ISMS ad-hoc committee on Forensic Medicine has prepared legislation to create a state wide medical examiner system. Our bill will be introduced in 1973.

"Certificate of Need" Bill Defeated: "Certificate of Need" is the common term in legislative circles for determination of the qualifications of persons establishing a hospital or long-term care facility and the planning and development of these facilities. This bill (HB 2653) and the concepts it envelopes is one of the most controversial and important issues confronting the doctors in Illinois. The ISMS House of Delegates has firmly established the policy that this type of health planning will only be supported when physicians are a significant part of the decision making process at the local level.

Doctors are not alone in their concern regarding the development of this issue. In August, 1972, the Chicago Home Rule Commission urged that the Chicago City Council (and not the state) should control where new hospitals and hospital extensions go. This issue will certainly be debated in the 78th General Assembly (Jan. 1973). All physicians in Illinois should become fully aware of the ramifications of such legislation and actively follow the developments on this matter in 1973.

Public Affairs Committee

The Public Affairs Committee sponsored several successful programs in 1972. The following is a brief outline of the Committee's activities in 1972 and the programs planned for 1973.

Merlin K. Duval, M.D., Assistant Secretary for Scientific Affairs, U.S. Department of HEW, was the featured speaker at the annual Public Affairs Dinner held during the House of Delegates Meeting, March 8, in Chicago. At the Auxiliary Public Affairs Breakfast, held March 9 in Chicago, Roy Pfautch, veteran campaign manager and well respected consultant, spoke on the "Changing Political Scene—How Doctors Can Cope." The annual Washington Roundup held April 16-18 featured meetings with congressmen and other key federal officials on national medical legislation.

A speakers' bureau for county medical societies, on legislative, governmental and political developments affecting medical practice in Illinois, has been developed and will actively function in 1973. Also, a brief slide presentation on the legislative process is being prepared for county medical society meetings and Auxiliary workshops.

The Public Affairs Committee is presently finalizing preparations for the program at the Washington-San Juan Roundup March 4-11, 1973. The annual Public Affairs Dinner has been discontinued in favor of an expanded Auxiliary Public Affairs Breakfast to be held March 27, during the annual ISMS Convention.

Ad Hoc Committee on the Legal Definition of Death

The ad-hoc Committee on the Legal Definition of Death has worked to devise a bill defining death. While a legal definition of death proposal was prepared, the Committee decided that unresolved legal questions should be answered prior to passage of a law defining death. In the event a bill is introduced into the legislature, the ad-hoc committee recommends that ISMS insure that all medical and legal issues be resolved prior to passage of the bill.

Eye Committee

The Eye Health Committee's major effort in 1972 was directed to HB 2033, a bill to eliminate the state-funded vision screening examination program. ISMS successfully opposed HB 2033, but the committee expects that a similar proposal will be re-introduced in 1973.

Ad-Hoc Committee on Forensic Medicine

The ad-hoc Committee on Forensic Medicine has finalized preparations on its legislative proposal to create a state wide medical-legal examining system. This bill will be introduced in the 78th General Assembly. The Committee's efforts will now be concentrated on forming an effective coalition to pass the bill.

Follow-up on House of Delegates Actions

The 1972 House of Delegates adopted and referred the following resolutions to the Governmental Affairs Council for implementation:

- **72 M-9** directed ISMS to affirm its desire to have all ambulance services meet minimum standards as soon as the statewide trauma network is fully implemented. Although legislation was pending before the General Assembly on this matter, the issue was defeated in the House Traffic Safety Committee where a Sub-Commission was appointed to study the situation. ISMS through its ad-hoc Committee on Emergency and Disaster Medical Care made specific recommendations to the Legislature on this matter. Legislation is expected to be introduced again in 1973. ISMS will reaffirm its position on this matter to ensure the upgrading of the present ambulance services.
- **72 M-18** called on the ISMS to urge AMA to join other professions in forming a multi-disciplinary Professional Rights Society. The Governmental Affairs Council drafted a resolution which was introduced into the AMA House of Delegates in June where the resolution was referred to the AMA Board of Trustees for study.

• **72 M-20** directed ISMS to study the "Getting Report" and submit its recommendations to the 1973 ISMS House of Delegates. The Council on Environmental and Community Health has evaluated the report and has its recommendations for the House of Delegates.

• **72 M-24** approved the concept of Physician's Assistants and urged a one year moratorium on enabling legislation. The sponsor of Senate Bill 24 agreed to the aims of the House of Delegates actions. The bill has been referred to the Illinois Health Care Licensure Commission for further study.

• **72 M-25** directed ISMS to seek legislation to permit Blue Cross to reimburse free-standing outpatient medical and surgical facilities for outpatient services. The Governmental Affairs Council is presently working with the ad-hoc Committee on Surgi-centers under the Council on Economics and Peer Review to finalize recommendations on this legislation. It is expected that legislation will be introduced in 1973.

• **72 M-28** directed ISMS to support an amendment to the drug labeling law allowing for M.D.'s to give verbal authorization for pharmacists not to identify the contents of a prescription. The Governmental Affairs Council informed the Illinois Pharmacists Association of the House of Delegate's action and legislation will be introduced in 1973.

Alfred J. Faber, *Chairman*

Theodore Balsam — Warren Kreft
Maurice Colbert — James Laidlaw
Edward Ference — Jerome Neustadt
H. Frank Holman — John W. Ovitz, Jr.
Grant C. Johnson — Robert Pierce
George Wilkins

Consultants

Willard C. Scrivner — George Shropshear
C. J. Jannings — Warren Tuttle
Robert Fox

Pam Taylor, *Auxiliary Representative*
Chris Gilman, *SAMA* — Tom Powers, *SAMA*

Public Affairs Committee

George T. Wilkins, *Chairman*

William Ashley — Elliott Partridge
Herschel L. Browns — Robert Pierce
Charles Downing — John L. Savage
Theodore Grevas — Julius P. Schweitzer
Jerry Ingalls — P. John Seward
Earl Klaren — Eugene H. Siegel
Frank J. Kresca — V. P. Siegel
Rocco Lobraico, Jr. — Herbert Sohn
W. Robert Malony — A. E. Steer
George T. Mitchell — Frederick E. Weiss
Donal D. O'Sullivan — Lorin D. Whittaker
Joseph Hinkamp
Mrs. H. J. Failor, *Auxiliary Representative*

Ad Hoc Committee on the Legal Definition of Death

Jacob E. Reisch, *Chairman*

Tom Baffes — William Dye
Fred Merkel — Edward Ference
Benjamin Boshes — Victor Wojner

Eye Committee

Warren W. Kreft, *Chairman*

Frederick Crowley — Edward Kwedar
Marshall Hirshman — Sam Schall
Maurice Hoeltgen — Frank Snell

Ad Hoc Committee on Forensic Medicine

Grant C. Johnson, *Chairman*

Thomas P. DeGraffenried — Donal D. O'Sullivan
James H. Ryan

CHAMPAGNE BRUNCH

Tuesday, March 27, 1973

8:00 a.m.

Conrad Hilton, Chicago

Medical-Legal

MEDICAL LEGAL COUNCIL

The Medical Legal Council has addressed itself to many significant concerns of the ISMS membership. Since the last meeting of the House of Delegates, the Council has met on numerous occasions and has made several specific recommendations to the Board of Trustees.

The Council is responsible for maintaining liaison with the Bar Associations, the Administrative office of the Illinois Courts and the Illinois Department of Registration and Education. We extend our gratitude to all those who have contributed to the work of this Council.

Within the Council are activities on Impartial Medical Testimony, Licensure and the Committee on Laboratory Services. Incorporated within this report are the actions of the Council and its constituent units.

Pilot Arbitration Projects: During the past year, representatives of the Council have met several times with individuals from the Illinois Hospital Association and the American Arbitration Association to discuss the potential for testing certain innovative, voluntary programs for arbitration of medical malpractice claims against physicians and hospitals. The proposal, as approved by the Board of Trustees, would supplement, not supplant, existing court procedures for resolving litigated malpractice claims on a pilot project basis. Upon approval by the IHA Board of Trustees, the Council hopes to implement the pilot arbitration program as soon as feasible.

In light of activities during the past year regarding arbitration, the Council suggested that the topic for this year's Leadership Conference be Malpractice. A major portion of the program was devoted to the use of arbitration as a method of dispute settlement. We believe those who attended the conference felt it was worthwhile.

Interprofessional Code: Again this year, problems regarding the Interprofessional Code have been brought to the attention of the Council. Problems center primarily around the questions of use of the subpoena and reimbursement for services as an expert medical witness. Representatives of the Council will be meeting with the appropriate committee of the Illinois State Bar Association in the near future.

Impartial Medical Testimony: During the past year, the Impartial Medical Testimony panel continued to provide valuable service to the Illinois and U.S. District Courts. In 1972, IMT panelists were utilized in 106 cases involving over 200 examinations. As in years past, the vast majority of the requests have been in Cook County. Probably the most significant change that has occurred during the last year, in addition to the record number of cases, is the number of psychiatric examinations requested. Seventy-five of the 106 cases ordered during this past year required psychiatric examinations.

Laboratory Services Committee

The Laboratory Services Committee devoted its attention to problems related to House Bill 4445 as signed into law by Governor Ogilvie. The intent of the law is to create a uniform voluntary blood donor system in the state by requiring that all blood must be labeled in a form specified by IDPH, which indicates whether the blood was obtained by purchase or donation. As the chairman of the Laboratory Services Committee is a member of the Governor's Task Force on Blood, the Council has maintained a close awareness of activities in this area.

Clinton L. Compere, *Chairman*

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George Alvery	Joseph L. Bordenave, Consultant
James Gladish	Fredric Lake, Consultant
Edward Grossman	Allan Goslin, Consultant
James Habegger	A. Everett Joslyn, Consultant
Vincent Sarley	Frederick E. Weiss, Consultant
Donal O'Sullivan	Gary Skaletsky, SAMA
Harold Sofield	John Dowdle, SAMA

Laboratory Services Committee
James Habegger, *Chairman*

Ronald Jessen	Thiru Viathianathan
John J. Mueller	Jack Williams
Peter Soto	Bernard Stodsky
Hans Willuhn	Earl Suckow
Richard Novak	Coye Mason

Mental Health and Addiction

COUNCIL ON MENTAL HEALTH AND ADDICTION

Since last reporting, the Council on Mental Health and Addiction has addressed itself to many topics. Specific actions have been recommended to the Board of Trustees in several concerns. There has been constant communication maintained with various voluntary agencies working in the field of mental health and mental retardation, with the Illinois Department of Mental Health, and with several groups active in the diagnosis, treatment and rehabilitation of persons addicted to alcohol or drugs.

Space does not permit complete detailing of every activity of the Council; however, a synopsis of the year's activities is presented. The Council:

1. Developed a brief booklet for all ISMS members titled "Hospitalization of the Mentally Ill," funded through the ISMS Educational and Scientific Foundation. The booklet is based upon a brief explanation of the procedures in the Illinois Mental Health Code.

2. Worked to defend against inclusion of health insurance payment for non-physician services, when not under the direction and supervision of a physician, as proposed by the Illinois Psychological Association for amendment to the Insurance Code.

3. Addressed a question of the Illinois Statutes as they relate to psychiatric considerations in abortion. No specific action taken.

4. Supported the formation of the Drug Abuse Council of Illinois, which would act as a catalyst and unifying force in bringing together the many divergent groups active in the treatment of drug abuse.

5. Considered several pieces of legislation introduced at the last session of the General Assembly to develop an Alcoholism Treatment Act. This currently is under continued study.

6. Recommended to the Department of Mental Health an increase in amounts budgeted for the emergency purchase of psychiatric treatment services for persons in the grey area of the working poor—those who are not eligible for public aid, but are not able to purchase their own mental health coverage.

7. Reviewed a proposed Comprehensive Mental Health Services Act for Illinois, recommending that modifications were necessary to retain local control of such services and to guarantee medical input; this will be considered again in the next session of the General Assembly.

8. Upon development by a member of the Council and with Council approval, an idealized treatment modalities outline was submitted for use by hospitals and psychiatrists throughout Illinois. These will be distributed to all concerned upon approval by Illinois Psychiatric Society and the ISMS Board of Trustees.

9. Reviewed the statutes regarding treatment of adolescents without parental consent and developed legislation to allow treatment for those 16 and over, on an outpaient basis, for mental disorders without parental consent (as is the present law for those with VD or a drug abust problem, except that in these two instances the physician may treat a child over age 12.)

10. Debated the adequacy of the $300 per year maximum coverage of Public Aid recipients for mental health care, as well as the 10/20 day limit on hospitalization of these individuals; it was recommended to have further review of this by the Council on Economics and Peer Review. The Council also objected to the lengthy forms required by IDMH for IDPA and the tardiness of payments.

11. Recommended inclusion of senior psychiatric residents in Impartial Medical Review cases where a psychiatric examination is ordered. This would build a pool of knowledgeable psychiatrists in this activity, since almost 50% of Impartial Medical Testimony cases now call for phychiatric review.

12. Discussed the sections of the Medical Practice Act regarding limited license physicians, and reviewed the anticipated crisis in state mental institutions should there be a complete phase-out of permit doctors. It was recommended that the Department of Mental Health utilize the services of fully licensed physicians and support was given for the special project committee to IDMH, which was developing educational standards and guidelines to appropriately categorize persons presently working as permit doctors.

13. At the direction of the Board of Trustees, testimony was developed and presented to the Illinois Department of Law Enforcement regarding rescheduling of controlled substances and extended application of the triplacte prescription form. This was in keeping with the 1972 Kane County resolution.

14. Established liaison between the Illinois Psychiatric Society and the Illinois Department of Corrections to enable psychiatric consultation to Illinois penal institutions.

15. Objected to increased malpractice insurance premiums for psychiatrists.

16. Recommended to the Board of Trustees that Hospital Licensing Board regulations suggesting psychiatric consultation for medical patients admitted by non-psychiatrists to psychiatric units be supported.

17. Prepared objections, subsequently approved by the Board of Trustees, to the reduction in availability of methadone for analgesic purposes and for use generally in treatment of heroin addiction.

18. Heard reports about two physicians who were engaged in illicit drug traffic and recommended appropriate action to the county medical society which detailed the problem.

19. Discussed community half-way houses with representatives of the Department of Mental Health and suggested possible activities to guarantee appropriate medical management of individuals being placed in these surroundings.

20. Supported proposed amendments to the Pharmacy Practice Act, the Food, Drug and Cosmetic Act, and the Medical Practice Act which would allow a physician to change labelling orders orally, rather than requiring a written notation.

21. Recommended to the Council on Education and Manpower that it suggest to the medical schools that sex education, alcoholism treatment, and drug abuse treatment, be added to medical school curricula as required courses.

22. Is in the process of reviewing insurance coverage in Illinois as it relates to treatment for alcoholism, with the view to identifying a method to have this coverage available as part of any health insurance written in Illinois.

23. Established small subcommittees to review current judicial activities in other states regarding constitutionality of commitment statutes and the malpractice judgements in mental health cases.

24. Worked in close harmony with the AMA and other state bodies to develop programs involving mental health.

This listing of 24 items gives an idea of the breadth and scope of 1972 activities. Council members, individually and collectively, were very active with a wide variety of agencies and groups. Several national meetings were covered by council members.

This summarizes our year activities. We addressed one item referred from the 1972 House of Delegates, extension of the triplicate prescription form, and, as noted above, developed testimony which was presented to the Department of Law Enforcement by ISMS President Frank J. Jirka, Jr.

Anyone desiring information on specific actions of the Council should address an inquiry to the council chairman or staff.

Marshall A. Falk, *Chairman*
Nathaniel S. Apter
Irving Frank
Abraham Gelperin
Walter P. Plassman
Alex Spadoni
W. David Steed
Donovan Wright
Ronald Shlensky
Howard D. Kurland
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Albert Glass, *Consultant*
John Schaible, *SAMA*
Bob Gilligan, *SAMA*
Mrs. John Koenig, *Aux. Rep.*

ILLINOIS DEPARTMENT OF MENTAL HEALTH

Fiscal Year 1972 saw a record breaking $330.5 million budget make possible a providing of greater services and program development for Illinois citizens. Significant accomplishments during the year included the announcement of a seven-point program to provide greater safeguards against medical abuses in state mental hospitals.

The Department of Mental Health also adopted the new regional planning system in place of the zone organization, and a study of Department administrative procedures was begun by task force members from the Governor's Advisory Council.

Construction project plans announced included: a 400-bed mental retardation facility to be built on the Chicago-Read Mental Health Center campus; groundbreaking for an $8.4 million, seven-building complex for children and adolescents at Chicago-Read; construction started on the new MR Center at Tinley Park Mental Health Center; and construction began on a modern Illinois Security Hospital at Chester which will provide the first services for women in a security hospital in Illinois history.

Elgin State Hospital's recently constructed $1.2 million children and adolescents center was formally dedicated, Madden Mental Health Center became fully operational with the opening of a sixth adult inpatient pavilion, and Chicago-Read established a new alcoholism unit.

Also significant was the fact that results of a survey of parents of the mentally retarded showed 83% thought services had improved.

In addition to the above accomplishments, 72 Department employees won superior achievement certificates in the Governor's Special Recognition Program. Fourteen placed within the top 50, and three were named in the top 10 of all state employees.

In retrospect, FY '72 was a very good year, and FY '73 holds much promise for continued progress and development of state mental health services in Illinois.

Adults

Adults make up more than 90% of admissions to Department psychiatric facilities. Thus they are the chief group, numerically speaking, to benefit from better organized and better funded Department programs.

Toward the end of the fiscal year, Governor Richard B. Ogilvie presented a budget aimed at continued buildup of a comprehensive community-based system of delivering mental health services.

Illustrating this buildup, more than 92,000 adults were served in state-aided clinics. (Active cases at the end of FY '72 plus all those separated during the year.) Appropriations for services in community clinics and day treatment centers now total more than $26 million. A program for purchasing hospitalization services from approved general hospitals with psychiatric units received an appropriation of $2 million.

Altogether, more than $78 million has been allocated by the state for grants and care purchased from community programs, reflecting the conscious decision of the administration to move away from institutional care toward care built around community and family.

The Elderly

In 1969, the DMH inpatient population 65 years of age and older was 7,201 or 25.8% of the total number of inpatients. By 1972, the population 65 and over had dropped to 2,918, which was 16.4% of the total. During this time, a strong effort was made to move elderly persons who were not mental patients out of Department facilities and into private geriatric care.

The Department is continuing to make improvements in the program. Through the combined resources, professionally and managerially, of the Department of Mental Health, the Department of Public Aid, and the Department of Public Health, the problems at skilled and intermediate nursing homes, as well as shelter care facilities are being alleviated.

The move into the community has stimulated the construction of many modern adequate facilities, especially at the shelter care level where there is now an overage of available beds.

The quality of care in skilled nursing homes is up to standard.

There are still shortages of adequate facilities at the intermediate stage.

A number of patients with true psychiatric problems remain in state hospitals; there probably always will be a core population of elderly people in each facility.

Emphasis now is on outpatient services, so that Department staff make regular thorough visits to the elderly placed in community facilities to assure not only their physical welfare, but their social, psychological and human well-being.

The Department is developing policies and techniques to better implement pre-admission examination programs. Federal Life Safety Code standards have been adopted to protect the elderly from the threat of accident. Statistical information has been computerized in an interagency data bank so that violations are located, investigations scheduled and made, and evaluations prepared with greater speed and accuracy.

Drug Abuse

The Illinois Drug Abuse Program doubled its clients this year. More than 5,000 persons are now receiving treatment in 41 facilities throughout the state.

Community involvement keynoted the expansion program. Seventeen new clinics opened through contractual agreements with community-based organizations. Local treatment centers are now operating in East St. Louis, Harvey, Maywood, Peoria, Rockford, Rock Island and Springfield.

New neighborhood clinics opened in Chicago in black housing projects on the near north and far south sides; in a multi-racial area near the loop; a black area on the west side; a middle-class white area on the far north; and Spanish speaking communities on the northwest and far north sides of the city.

Expansion this year also was seen in types of services. Once limited to treating heroin addicted persons, the Drug Abuse Program now offers help to young poly-drug users as well. Youth centers on the north and south sides of Chicago provide individual, group and family counseling in both residential and outpatient settings.

Emphasis also was given to simplifying and improving data collection and research operations of the program. Research projects included studies on a long-lasting narcotic substitute similar to methadone, study of techniques of handling methadone detoxification and the development of successful treatment approaches for the pregnant addict.

A leadership training program serves as an advisory council to review all the Program's personnel and policy decisions. Because 9 of its 15 members are ex-addicts, it represents a unique approach to management training in the drug abuse field.

Plans are underway for a comprehensive statewide epidemiologic program.

Children

During FY '72, the Department of Mental Health pioneered in concern for the civil rights of children. A Department rule gave civil rights to minors over 13 years of age in mental hospitals on a voluntary basis. This enabled those youths to assume responsibility for participation in their own treatment. Adolescents were removed from Illinois Security Hospital.

Southern Illinois took major steps toward realization of "children mental health centers" with the development of units for emotionally disturbed children in mental retardation facilities at the Murray and Bowen Children's Centers.

A number of other new program developments consistent with overall policy took place. These included the completion of the first year of the joint Children's Program at Tinley Park. This program is a collaborative effort between the Departments of Children and Family Services, Corrections, and Mental Health serving acting-out adolescents who cannot be served in other facilities.

Elgin State Hospital dedicated its newly constructed $1.2 million Children and Adolescents Service Center.

Groundbreaking ceremonies were held for a new $8.4 million, seven-building complex for children and adolescents, located on the grounds of Chicago-Read Mental Health Center on Chicago's northwest side.

The Department's statement of policy on services for children and adolescents was ratified and adopted. Representatives responsible for children and adolescent services in each of the regions were designated. In addition, in some of the larger regions, such representatives were also appointed on a subregional basis.

Mental Retardation

Programs for the mentally retarded continued in 1972 with emphasis on community involvement and development of a "homelike" atmosphere in care facilities.

The first of seven new centers for the retarded moved toward completion in the Chicago area. The Elisabeth Ludeman Center which opened its doors this fall to residents, has the design of a subdivision and a homelike environment.

Populations were once again reduced at both Lincoln and Dixon State Schools. Lincoln dropped from its 1971 figure of 2671 to 2286 in 1972, and Dixon from 2643 in 1971 to 2569 in 1972. Plans are for Dixon to have a population of 2200 and Lincoln 2000 in 1973.

Some 410 state school residents have been transferred to units for the retarded in facilities for the mentally ill.

Interim care grants were issued to 126 facilities serving 1781 residents. There were 102 day care centers serving 8557 persons and four community living facilities serving 84 residents.

Alcoholism

The federal government approved the Illinois State Plan for the Prevention, Treatment and Control of Alcohol Abuse and Alcoholism. An award of $1,367,259 was made to carry out the provisions of this Department-authored plan.

The grant will include a state survey, regional and "inner city" development and a model demonstration program for alcoholic employees.

An alcoholism review team will be established in each of the state's seven regions. These survey teams will determine what services are being given by each of the alcoholism treatment agencies. Teams also will make a follow-up evaluation. Results will serve as the basis for awarding grants, both state and federal.

A federal staffing grant of $50,000 has been received to set up a State and Industrial Employee Occupational

Alcoholism Program. The model program will demonstrate an approach for dealing with alcoholic employees, both in government and private industry.

In FY '72 the Department distributed $650,015 ($200,000 increase) in grant-in-aid funds to local alcoholism community councils, who coordinate community efforts to treat and counsel alcoholics.

A Directory of Illinois Alcoholism Resources, providing information on more than 250 facilities, was published for the first time. It will be updated yearly.

By order of the Governor, the Department of Mental Health is now the official state agency for all federal and state alcoholism programs. All grant applications, both state and federal, must be submitted to this agency.

Research

Scientific research and development continue in six major laboratories. These programs increasingly are involved with immediate mental health and mental retardation problems.

A decade ago, great scientific achievements in outer space, in conquering polio, and in breaking the genetic code led to widespread enthusiasm for basic research. The Department joined a nationwide, multi-disciplinary effort to discover basic solutions to mental disorders.

Impressive gains were made. Studies of naturally-occurring brain substances suggested biological bases for schizophrenia and depression. Laboratory analyses of behavior led to powerful new behavioral therapies. The social fabric of psychological disturbances became better understood. Department laboratories actively participated in these efforts.

Optimism remains for eventual clarification of the causes of mental illness and retardation, and their prevention. However, society is impatient for relief from today's enormous social and psychological burdens to the laboratories are in a uniquely favorable position to respond to the cry for help.

Basic laboratory research can prosper in many different settings, but having research laboratories in mental health facilities involves department scientists with immediate problems. They are engaging in a wide range of clinical research and development efforts. These include nationally acclaimed innovative methods of behavioral retraining and therapy, particularly with the mentally retarded; widely-recognized studies of the biochemistry of schizophrenia and of depression; analysis of a major referral system for children's mental health services; research on conditions which may produce damage in the developing brain; analyses of the destructive effects of some social institutions upon the psychological development of youth. One laboratory has been entirely changed to find ways of improving effectiveness in the use of therapeutic drugs. All efforts of DMH are further advanced through

Albert Glass, M.D., *Director*

President's Night

Honoring

Frank J. Jirka, Jr., M.D.

President

Illinois State Medical Society

Tuesday, March 27, 1973

Boulevard Room, Conrad Hilton Hotel

6 p.m. Reception

7 p.m. Dinner

Featuring Franz Benteler and the Royal Strings

Public Relations and Membership Services

COUNCIL ON PUBLIC RELATIONS AND MEMBERSHIP SERVICES

The Council on Public Relations and Membership Services continued to maintain a positive approach in its communications programs both internally and externally during 1972. It emphasized the "good things" by every available means. At the same time, the Council recognized that organized medicine, along with every other segment of our increasingly complex social structure, was having its problems. As ISMS leadership probed into the problems and sought for solutions, the Council in turn took a strong position to inform the public, other health organizations and government bodies and the membership itself of these actions.

Action Report: Launched in May, this biweekly publication capsules socio-economic news of special interest to physicians. It keeps physicians informed of developments in HASP and other IFMC functions; new Medicare and Medicaid regulations; ISMA-AMA delegation actions; court decisions effecting medicine and other news. More than 4,200 ISMS members receive Action Report as a major source of professional information.

President's Tour: Dr. Frank J. Jirka, Jr., served as an eloquent spokesman for ISMS in his speeches before Rotary, Kiwanis and other civic groups and 13 county medical societies in all of the state's 11 districts. He concentrated on the need for preventive medicine, health education and involvement of both physicians and consumers in health care delivery in his civic group talks and in 36 newspaper, 16 radio and six TV interviews.

The scope of the District Feedback sessions was expanded with Dr. Jirka and the district trustee fielding the questions and problems of participating physicians. Meetings of medical assistants, held in conjunction with the tour, were well attended (see report of Council on Economics and Peer Review).

Journalism Awards Program: Again in 1972, this event was held to honor "distinguished achievement in medical journalism" in a variety of categories covering all media. Eighteen winners were selected from more than 200 entries and presented with symbolical plaques after a colorful and dramatic visual presentation at a banquet at the Playboy Towers Hotel. The plaques were becoming more and more coveted by journalists as the event approached its 9th anniversary.

Health Education: Dr. SIMS health education programming was successful in several different areas. "Dr. SIMS Talks to Teens," a monthly series of health columns for high school newspapers, appeared in more than 400 papers. Health tips are carried regularly by some 80 radio stations and 40 daily newspapers.

Doctor's Job Fair: Organized and run by the ISMS Physician Placement Service to attract doctors to communities where they are badly needed, the Fair is made up of booths manned by mayors, chamber of commerce representatives and other civic leaders. Newly licensed physicians, or those looking for new places to practice and live, visit the booths and find out what the communities have to offer. Special efforts were made to secure maximum publicity for this second Fair held at the Regency Hyatt House, O'Hare. Live coverage of the event included filmed reports by crews from NBC-TV, ABC-TV and WGN-TV. The NBC coverage was picked up by the full network via "The Today Show." Two of the four Chicago papers and several downstate papers sent reporters to the scene; other papers and radio stations covered it from telephone reports and news releases. The releases were "personalized" to papers in the 60 towns represented at the Fair by pointing out local representatives who would be on hand to interview doctors.

Medicare Misconceptions: More than 500,000 copies of this pamphlet, clarifying Medicare benefits and explaining its limitations, were distributed for use by physicians, hospitals and other institutions The pamphlet was revised and updated at the end of the year in accordance with H.R.1., the Social Security amendments of 1972.

New Programs: The Council has discussed a number of new programs for 1973 and the revival of others in somewhat different formats. Among those decided upon and implemented as this report was written: **Legislative TV News Interviews:** Basically, this program consists of two-minute segments for news shows of sound-on-film interviews of key members of the Illinois Senate and House to get their views on current and pending health bills. One interview a week of each of six legislators is being filmed and distributed to appropriate TV stations. The news interviews have multiple public relations-publicity values: the legislator welcomes the exposure in his community; the TV news director is glad to present current news direct from the General Assembly; the public is informed of important developments in the health field and ISMS gets credit in most cases.

Legislative TV Discussion Shows: These shows are planned to put the news interviews into more depth by placing legislators and physicians into a situaion whereby they can talk at some length about health care issues. Several TV and radio stations in key population centers have agreed to air the programs.

Especially concerned with membership matters, the Council formed in mid-year an Ad Hoc Committee on Membership Recruitment and Retention. After an initial study of membership problems, the Council and the

Committee recommended production of a membership retention pamphlet in cooperation with the Chicago Medical Society and under the partial funding of the AMA. This pamphlet was produced and distributed to more than 7,000 members of CMS along with their 1973 billing statement. Its adaptation for use in other counties and as a recruiting tool is being studied.

The Council is now investigating plans for a massive telephone recruitment campaign which it would offer to county medical societies for implementation. This project would be conducted by personal calls from ISMS members to nonmembers on a quota system of so many calls per week per physician.

Council

Lee F. Winkler, *Chairman*

Paul J. Biedenharn — Raymond H. Conley
Catherine L. Dobson — William F. Hensold
Charles W. Pfister

SAMA Representatives

Connie Norgaard — Paul J. Hering

Consultants

Fredric D. Lake — Philip G. Thomsen — Charles L. Weigel
Mrs. Clement P. Cunningham, *Auxiliary Representative*

Ad Hoc Committee on Membership Recruitment and Retention

Catherine L. Dobson, *Chairman*
Paul J. Biedenharn — Raymond H. Conley

PHYSICIAN PLACEMENT SERVICE

During the past year, the Physician Placement Service, placed 26 physicians in the following towns: Chicago, Quincy, Northlake, Danville, Belleville, Woodstock, Aurora, St. Charles, Arlington Heights, Kewanee, Rockford, Elgin, Park Forest, Marion, Waukegan, Bradley, Bloomington, and Oak Forest.

Although most of the above placements are for physicians in specialty positions, it has been noted that the trend of Family Practice in small towns may be on the upsurge.

On December 3, 1972, the 2nd annual Doctor's Job Fair was held at the Regency Hyatt House, Chicago. Over 63 communities and clinics participated in hopes of securing a physician. All physicians registered with the placement service, physicians taking the FLEX examination, and interns and residents from the Chicago area were invited, with over 318 physicians attending this one-day conference. Dr. Charles J. Jannings, III, Fairfield, spoke on "What a Doctor Looks for in a Community."

The Doctor's Job Fair was considered a success, in terms of nation-wide coverage via newspapers, radio and TV. However, the full outcome of the meeting may not be known until later this year when the physicians and communities representatives who met at the Job Fair have an opportunity to negotiate actual placement.

Due to the increased cost of maintaining the Physician Placement Service, the Board of Trustees voted to charge communities a nominal fee for: 1) exhibit space at the Doctor's Job Fair, 2) advertising in the *IMJ*, and 3) staff services involved in transmitting the credentials of more than 500 physicians whose applications are received annually by ISMS. Thus far, this has been well received by the communities and the first "Physician Recruitment Program" was published in the January, 1973, *IMJ*.

FIFTY-YEAR CLUB

In 1972, the Fifty-Year Club was increased by 83 new members, those having graduated from medical school in 1922, bringing the total membership to 601.

A luncheon was held on March 9, 1972, at the Conrad Hilton Hotel, Chicago, during the annual meeting of ISMS, and the midwest clinical conference, which was attended by 198 members and their families.

Dr. William B. Adams, Acting Chairman of the Fifty Year Club, presented the plaques and pins to all new members. Lee Fischer, senior medical student, Abraham Lincoln School of Medicine, University of Illinois, gave a well received talk to the group. The new Fifty-Year Club roster was distributed at the luncheon.

President's Night

March 27

Public Affairs Breakfast

March 27

Conference on Professional Standards

March 25

Social and Medical Services

COUNCIL ON SOCIAL AND MEDICAL SERVICES

During the year, the Council considered matters related to overall health care facilities; hospital services, including emergency room and disaster medical care; ambulance service standards; problems of the aging; rehabilitation education; and health care of the poor.

In the interest of obtaining proper training of emergency medical technician-ambulance personnel and to ensure the high quality of emergency patient care, the Council explored ways to obtain legislation requiring all medical procedure training (such as intubation, aspiration, IV, ECG) to be conducted by physicians or specially trained nurses under the direction of a physician.

The Council also recommended that all medically oriented curriculum materials be reviewed continuously by a committee of physicians knowledgeable in the care of the trauma victim or emergency, non-ambulatory patient.

A memo was sent to all county medical society secretaries and chiefs of staff of all Illinois hospitals urging physician participation and leadership in implementing the new rules and regulations pertaining to hospital licensing, as outlined in requirements for development of areawide emergency service committees.

In the specific field of Ambulance Service Standards, the Council:

- Opposed any legislation calling for standards that would threaten existing ambulance service in Illinois or which would substitute the Trauma System for local services;
- Supported activities that would make the Trauma System a source of training, direction and support for existing services;
- Encouraged utilization of all local facilities such as civil defense, fire departments and other volunteers;
- Encouraged adoption of the Medical Self Help Training course as a minimum training requirement;
- Encouraged ambulance operators to voluntarily upgrade training and equipment;
- Worked to extend the Good Samaritan concept to the emergency room.

In view of the constant criticism of the quantity and quality of nursing home medical care, the Council and its Ad Hoc Committee on Aging recommended that appropriate action be taken to insure that:

- Every licensed nursing home patient has an active attending physician who acknowledges his continuing responsibility in writing;
- Every such attending physician assumes adequate responsibility for finding and designating a specific substitute in the event he cannot fulfill this professional obligation;
- In the event attending physicians fail to properly exercise either of their responsibilities, licensed nursing homes take prompt and appropriate action to obtain new active attending physicians;
- All patients and responsible family members are fully informed regarding these requirements and are fully consulted prior to undertaking any of the foregoing arrangements;
- All interested parties are promptly informed regarding the identity of attending physician's status;
- Local medical societies accept full responsibility for enforcing all of the foregoing through peer review and other appropriate committee activity; and
- The public aid policies on reimbursement of physicians serving nursing home patients be clarified.

As the reporting period drew to a close, the Council had launched an intensive investigation of ways and means to improve health care of the poor. It was defining the problem itself in the realization that: More doctors in ghetto and some rural areas is far from the total answer to the health problems of the poor; that illness itself is often not the cause of their health problems, but the effect of many other situations such as faulty nutrition, sub-standard housing, unemployment and lack of recreation facilities.

The Council also was exploring methods of increasing physician knowledge of physical and occupational therapy and other rehabilitation disciplines. Under study is a plan to form workshops and seminars on rehabilitation enlisting the help of authorities in that field to head the discussions.

Council

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Carl E. Clark	Aaron M. Rosenthal
Matthew B. Eisele	Paul G. Theobald
Kenneth A. Hurst	Thomas T. Tourlentes
Max Klinghoffer	Oliver Crawford, *SAMA*
James C. Reid	Robert J. Herfkins, *SAMA*

Paul W. Sunderland, *Consultant*

Ad Hoc Committee on Emergency and Disaster Care

Matthew B. Eisele, *Chairman*

Harold C. Lueth	William A. Hark
Max Klinghoffer	Eugene P. Johnson, *Consultant*

Charles P. Jannings, III, *Consultant*

Ad Hoc Committee on Health Care of the Poor

Aaron M. Rosenthal, *Chairman*

Dean R. Bordeaux	Willard Scrivner, *Consultant*
Paul W. Clark	Fred Z. Write, *Consultant*
Lawrence Hirsch	Robert Greifinger, *Consultant,*
Hugh R. Savage	Mrs. Sylvia Fox, *Consultant,* ASPIRA
Alphonso Robinson	Mr. Wali Siddiq, *Consultant,* Council on Bio-Medical Careers
	Mr. Gary Schwartz, *Consultant,* AMA

Ad Hoc Committee on Rehabilitation Services

Joel S. Rosen, *Chairman*

James C. Reid	Aaron M. Rosenthal

Ad Hoc Committee on Aging

Thomas T. Tourlentes, *Chairman*

Julian W. Buser	John W. Bowden
Kenneth A. Hurst	Bertram B. Moss

ILLINOIS DIVISION OF VOCATIONAL REHABILITATION

Persons with a partial handicap severe enough to substantially interfere with work can get DVR help if there is a reasonable expectation of being able to work after one or more of the following services are provided or purchased to reduce the handicap or prepare for work:

- Vocational Guidance
- Diagnostic Evaluation
- Medical, surgical, psychiatric treatment
- Hospital care
- Prosthetic or sensory devices
- Psychological testing
- Vocational training
- Transportation or Maintenance
- Books and Supplies
- Placement and followup

Financial need is a requirement for all servcies except Guidance, Training, Diagnosis, and Placement. This State-Federal partnership program has been in effect in this country for 52 years, since Woodrow Wilson signed the Vocational Rehabilitation Act in 1920. Over two million disabled persons in the United States have been prepared and placed in almost all kinds of jobs. Thousands of Illinoians have been helped to overcome such disabilities as arthritis, blindness, orthopedic limitations, mental illness, heart trouble, deafness or hearing difficulties, speech impairments, stroke, epilepsy, among many others.

Disabled people have landed almost any job you can name: construction worker, warehouseman, mechanic, cleaner and dyer, railroad brakeman, watchmaker, farm manager, trapper, cook, waiter, bookkeeper, clerk, salesman, civil engineer, physician, dentist, hotel manager, among many others. In some cases, disabled housewives have been helped to learn better ways of managing a household in cooking, cleaning, and child care. Vocational counselors assist the disabled person and arrange for help for his disability and in preparing for a job.

An important opportunity for employment of blind persons is offered by the Illinois Division of Vocational Rehabilitation's Vending Stand Program for the Blind. On sale at these stands are such commodities as tobacco, candy, confections, and food items. Vending stand income compares favorably with that of most small retailers.

An act of Congress provides for certain preference for blind people in the operation of vending stands in Federal buildings and grounds. However, about two-thirds of the stands are in non-Federal buildings and are established with the cooperation of the Illinois Division of Vocational Rehabilitation.

Priority is given to people receiving public aid, and to public offenders. A disabled person, instead of being supported by taxes his fellow Americans pay, is himself a taxpayer, once he goes to work. For every Federal dollar invested in his rehabilitation he will return an average of $5 to the U.S. Treasury in Federal income taxes during the remainder of his working life. Everybody benefits.

But the most important person to benefit is the disabled person himself. Through this program, he has been enabled to live an independent, productive life.

Alfred Slicer, *Director*

Resolutions

Resolution 73M-1

Introduced by: William Lees, Chairman, Board of Trustees

Subject: Continued Start-up Funding for Illinois Council on Continuing Medical Education

Referred to: Reference Committee on Finances and Budgets

WHEREAS, the House of Delegates in 1971 recognized the growing need of and demand for continuing medical education by authorizing establishment of the Illinois Council on Continuing Medical Education, a unique organizational approach that unites the energies and resources of ISMS, Illinois physicians, and the State's medical schools, and

WHEREAS, the House expressed its full support for the ICCME concept by allotting for the Council's use, half ($10) of the 1972 AMA-ERF assessment as start-up funds, further providing that these funds be held in escrow until ICCME should become operational, and

WHEREAS, effective September 1, 1972, the ICCME Board of Directors employed its first Executive Director, thus becoming operational, and has since proceeded with detailed planning to improve continuing education opportunities for Illinois physicians, and

WHEREAS, the funds allotted in May of 1971 suffice for the final third of 1972 and for 1973, but not beyond, and

WHEREAS, ICCME must deliver services before it can generate self-sustaining funds through its activities, and

WHEREAS, acting on the recommendation of the Executive Committee, the Board of Trustees at its meeting of October 14-15, 1972, unanimously voted to request the 1973 House of Delegates to resume its $10-per-member allocation of AMA-ERF contributions to ICCME for 1974 funding; now therefore be it

RESOLVED, that $10 of each ISMS member's 1974 contribution to the AMA-ERF be given to the Treasurer of ICCME for use in CME activities as determined by the ICCME Board of Directors during and after the calendar year 1974.

Resolution 73M-2

Introduced by: John W. Ovitz, Jr., for the Special Project Committee with Ill. Dept. of Mental Health

Subject: Cooperation with Local Units of the Illinois Department of Mental Health

Referred to: Reference Committee on Environmental Community and Mental Health.

WHEREAS, both systematic research and long experience over the decades, throughout the nation, have made plain that long-term hospitalization in large institutions does not benefit the bulk of patients with mental illnesses; and

WHEREAS, the Illinois Department of Mental Health has made major progress in meeting this problem, through the establishment of outpatient services, local community health clinics, and contract arrangements with impatient general hospital psychiatric units, and has had a role in the development of rehabilitation programs in sheltered workshops and in extended care facilities

for local communities; and

WHEREAS, there is ample evidence that decentralized treatment of mental disease greatly reduces the cost of mental patient care; and

WHEREAS, crucial to the success of the local-treatment approach abetted by the Department of Mental Health is full cooperation by local physicians in their roles as community leaders, as well as the cooperation of other local health personnel, local hospitals, and other community institutions, now therefore be it

RESOLVED, that the House of Delegates urges upon each constituent county society, and each branch of the Chicago Medical Society, that it cooperate fully with and support local units of the Department of Mental Health in their patient care efforts, specifically seeking to insure that

1. Local general hospitals accept mental health patients who can be helped by short-term treatment, leaving to State institutions responsibility for such chronic and long-term cases which local hospitals cannot presently handle:

2. Local general hospitals and practitioners retain in their own care those geriatric patients who have primarily physical ailments;

3. Local physicians, local hospitals, and local skilled nursing facilities provide primary and secondary care for psychiatric problems to the extent possible given facilities and physician-time available;

4. Arrangements for emergency mental health care, i.e., crisis intervention, be provided in each locality;

5. To the extent needed, local physicians and other health care personnel be properly trained to enable them to provide primary and secondary mental health care; and be it further

RESOLVED that all physician and other health service provided under such arrangements would be on a fee-for-service basis, paid either by the patient or third party insurers (private health insurance, Medicare, Medicaid, etc.).

Resolution 73M-3

Introduced by: C. J. Jannings, III, Wayne County Medical Society

Subject: Health Care Insurance and Cash Grants for Public Aid Recipients

Referred to: Reference Committee on Economics, Peer Review, Social & Medical Services

WHEREAS, Society as a whole, and the Illinois Department of Public Aid in particular, considers food, clothing, shelter, fuel, transportation, and other items as essential for the maintenance of a minimum standard of health and welfare and makes a cash grant to recipient in an amount calculated to be sufficient to meet these minimum requirements, and

WHEREAS, health care in general and medical care in particular is also considered to be an essential element to the maintenance of the health and welfare of an individual, and

WHEREAS, an expensive, unwieldy, bureaucratic nightmare has resulted from an attempt to bring services to recipients rather than to provide adequate insurance and cash grants to meet the expense of medical care, now therefore, be it

RESOLVED, that this House of Delegate propose the following program to the Governor, the Legislature, and the Department of Public Aid of the State of Illinois. 1. The Department of Public Aid purchase for each recipient a comprehensive health care policy which provides for the broadest type of In-Patient and Out-Patient health care benefits, including preventive maintenance, check-ups, immunizations, etc. and II. Include in the cash grant of all receipients of sum calculated to meet the co-payment and deductible cost which will be required at the time any service is rendered to a recipient (for example, a $1.00 deductible fee will be required for each out-patient visit, except in case of emergency, and a $5.00 deductible fee plus an additional $1.00 per day co-payment will be required for all in-patient care, except in case of emergency).

Resolution 73M-4

Introduced by: Fredric D. Lake, for the Committee on Constitution and Bylaws

Subject: Amendments to Bylaws

Referred to: Reference Committee on Amendments to Constitution and Bylaws

RESOLVED, That the bylaws of the Illinois State Medical Society be amended to read as follows:

CHAPTER I. MEMBERSHIP

A. *Regular members.* Regular members shall be those physicians licensed to practice medicine in all its branches in the State of Illinois, who are residents of the State of Illinois, persons of good moral character and professional standing and members of their component society. *Members in good standing moving out of Illinois may retain membership (not to exceed one year) in the Illinois State Medical Society until they are accepted into membership in the medical society of the state to which they have moved.*

E. *Retired members.* Retired members shall consist of those who have been regular members and who by reason of age or incapacity have retired from active practice and who upon application and recommendation from their component society have been made retired members. *Retired status is not available to physicians who assume compensated administrative positions after retiring from medical practice.*

CHAPTER IV. HOUSE OF DELEGATES

Section 9. *Order of Procedure.* The order of business of the House of Delegates will be determined by the Speaker, subject to approval by the Reference Committee on Rules and Order of Business. [Delete: Sturgis Standard Code of Parliamentary Procedure, Current Edition, shall be the guide for all procedures when not in conflict with the Constitution and Bylaws.]

CHAPTER V. ELECTION OF OFFICERS

Section 3. *Terms of Office.* The president-elect, vice president, secretary-treasurer, the speaker and vice speaker shall be elected annually by the House of Delegates to serve for a term of one year.

Members of the Board of Trustees shall be elected by the House of Delegates to serve a term of three years.

The speaker and vice speaker shall not be elected for more than [Delete: three] *two* consecutive terms to their respective offices; they shall be elected from the membership of the House of Delegates.

CHAPTER VI. DUTIES OF OFFICERS

Section 2. *The Vice Presidents.* The vice presidents shall act for and perform such duties for the president as he shall direct. They shall, when so acting, implement and advance the programs and policies of the president.

In the event of the President's death, resignation or removal from office, the first vice president shall succeed to the presidency.

In the event of a vacancy in the office of first vice president, The [Delete: president shall fill the office by appointment] *second vice president will become first vice president.*

CHAPTER VII. THE BOARD OF TRUSTEES

Section 1. *Composition.* The Board of Trustees shall consist of nineteen trustees elected by the House of Delegates [Delete: (nine shall be chosen from district number three, and one each from each of the other ten districts (see map attached, these districts of the geographical area as of May, 1946)] and one trustee-at-large (the retiring president, who shall serve a term of one year), the president, the president-elect, the speaker *and vice speaker of the House of Delegates, the first and second vice presidents,* and the secretary-treasurer. *Nine trustees shall be chosen from District 3 and one from each of the other ten districts as defined on the geographical map of the state approved in May 1946.*

[Delete: The vice presidents and vice speaker shall attend meetings (including executive sessions), with the right of discussion, but without the right to vote.]

CHAPTER IX. COMMITTEES

Section 2. *Councils*

1. The Council on Affiliate Societies shall be concerned in the areas of:

1. Liaison between parent society and ISMS
2. Scientific resource information and advice to ISMS
3. Consultation to other councils, e.g., postgraduate education, health care delivery, publicity ,legislation
4. Advances of medical science in special fields

Section 3. *Organization of Councils*

B. Affiliate Societies

1. Qualifications. Affiliate societies shall be those recognized specialty societies of Illinois
a) as may be approved by the Board of Trustees;
b) which desire representation on the Council on Affiliate Societies

B. *Representation. Affiliate societies shall be entitled to one member on the Council, who will be a member of the ISMS*

G. Term of office of members of the councils shall [Delete: not be more than three years] *be one year,* but may be terminated at any time at the discretion of the Board. No member of a council shall serve more than [Delete: Three] *five* consecutive *one year* terms. [Delete: Service of two or more years in an unexpired term shall be considered a full term.]

Section 6. *Board of Trustees Committees.* The Board of Trustees shall form the following committees within itself:

A. The Executive Committee shall consist of the president, president-elect, the *first vice president,* the chairman of the board, the chairman of the Finance and Medical Benevolence Committee, the chairman of the Policy Committee, the secretary-treasurer, the trustee-at-large and the immediate past chairman of the Board, provided he is still a trustee.

CHAPTER X. COUNTY SOCIETIES

Section 9. The secretary of each componet society shall forward its roster of officers and members, and a list of delegates and alternate delegates to the secretary of this Society before [Delete: The first Wednesday of January each year] *December 1 each year.*

CHAPTER XII. PEER REVIEW

Part 1. Component Society Procedure

Section 2. The committee shall consist of a chairman and such members representing [Delete: both general practice and] various specialties, *including family practice,* as each individual county society shall determine. Such committee should have access to counsel from each of the various medical specialties. The component county may establish reasonable rules of procedure but shall not be bound by the technical rules of evidence as the same pertains in courts of law. All proper complaints shall be reduced to writing and shall be signed by the individual making the complaint.

CHAPTR XV. PARLIAMENTARY PROCEDURES

For those matters not covered by the Constitution and Bylaws of the Illinois State Medical Society, Sturgis Standard Code of Parliamentary Procedure, current edition, shall be the guide for conduct of meetings of the House of Delegates, Board of Trustees and all councils and committees.

Resolution 73M-5

Introduced by: Jack L. Gibbs, for the Council on Education and Manpower

Subject: Continuing Medical Education and Continued Licensure

Referred to: Reference Committee on Education and Manpower

WHEREAS, recommendations have been made by various groups, such as the Illinois Hospital Association and the HEW Malpractice Study Commission, which would require re-examination of physicians for relicensure, and

WHEREAS, physicians are concerned with maintaining knowledge and clinical competence, and recommendations for re-examination for re-licensure stem from a lack of awareness of this and about the amount of time spent by physicians in continuing medical education individually and on a formal coursework basis and,

WHEREAS, a rapid increase in new techniques, pharmaceuticals, and basic medical acumen would indicate a need to encourage all physicians to continue to engage in continuing medical education, and

WHEREAS, various alternatives have been suggested at several levels of government in various states, by other state medical associations, and by specialty boards, said alternatives dealing with voluntary versus mandatory requirements for continuing medical education for continued licensure, or re-registration, continued staff privileges, continued specialty society or board membership, or even re-examination for relicensure, and

WHEREAS, the aim of legal requirements should be the improvement of health care, and

WHEREAS, the aim of continuing medical education is improved patient care, and continuing medical education and

WHEREAS continued updating of knowledge can best be accomplished through individual assessment of personal need, and

WHEREAS, the decentralization of medical education throughout the state will make continuing medical education increasingly accessible to all practicing physicians, and

WHEREAS, physicians have shown leadership, through the Illinois Council on Continuing Medical Education, the Council of Deans, and the AMA Physicians Recognition Award, and continue to emphasize the need for medical education at all levels, now, therefore be it

RESOLVED, that the Illinois State Medical Society reaffirm its support for and recommend that the Physicians Recognition Award of the American Medical Association or its equivalent serve as the basic eligibility requirement for re-registration, and be it further

RESOLVED, that the Illinois State Medical Society continue to support the activities of the Illinois Council on Continuing Medical Education to the extent authorized by this House of Delegates, and be it further

RESOLVED, that the Illinois State Medical Society develop the appropriate mechanism for accreditation of continuing medical education programs, subject to approval by the AMA, by empowering the Council on Education and Manpower to accomplish this activity, and be it further

RESOLVED, that the Illinois State Medical Society endorse the concept of continuing education as the condition for continued re-registration of health professionals, provided that the Illinois State Medical Society, with the assistance of medical schools of Illinois, has a role in certifying the educational quality of continuing medical education programs.

Resolution 73M-6

Introduced by: E. K. DuVivier, for the Madison County Medical Society
Subject: Combined Public Aid-Medicare Billing and Payment
Referred to: Reference Committee on Economics, Peer Review, Social and Medical Services

WHEREAS, Confusion exists on the eligibility and payments for both the Illinois Department of Public Aid and Medicare patients; therefore be it

RESOLVED, That physicians will be only required to bill one agency for the total fee. The agency shall be the Illinois Department of Public Aid. It shall arrange collection of that part of the payment due from Medicare.

Resolution 73M-7

Introduced by: George Wilkens, for the Madison County Medical Society
Subject: IMPAC-AMPAC Family Membership
Referred to: Reference Committee on Public Relations, Membership and Miscellaneous Business

WHEREAS, The Illinois Medical Political Action Committee (IMPAC) has achieved a notable record of success in electing friends of Illinois medicine to public office at the state and federal level; and

WHEREAS, IMPAC has proven to politicians and governmental bureaucrats alike that the Illinois physician community is a powerful force which must be reckoned with; and

WHEREAS, Government encroachment in the health care system must be dealt with through increasingly effective means of political action; and

WHEREAS, Joint billing of IMPAC dues of physicians and their spouses in Indiana and Kentucky has proven to be a very successful means of increasing participation in the Medical Political Action Committees in these states; therefore be it

RESOLVED, That, beginning in 1974, the Illinois State Medical Society dues statement be redesigned for the purpose of billing the IMPAC-AMPAC contribution as a joint contribution from physicians and their spouses. This new family membership will combine the $25 annual contribution for the physician and the $20 annual contribution for the physician's spouse. The new statement will read IMPAC-AMPAC Family Membership . . . $45. This contribution will continue to be voluntary.

Resolution 73M-8

Introduced by: Morgan M. Meyer, for the DuPage County Medical Society
Subject: Use of Statement of Understanding
Referred to: Reference Committee on Economics, Peer Review, Social and Medical Services

WHEREAS, third party carriers make their own determinations of what constitute usual and customary charges; and

WHEREAS, fee profiles are then compiled for large geographic areas, resulting in unrealistic profiles when applied to actual, usual and customary fees in a particular area; and

WHEREAS, this results in a deterioration of physician-patient relationships when fees are disallowed by the carrier; be it therefore

RESOLVED, That the Illinois State Medical Society urge the American Medical Association to encourage physicians nationally to educate patients regarding their responsibility to the physician for the payment of fees through the general use of the statement of understanding which reads as follows:

Statement of Understanding

I agree that the determination of professional services to be rendered by my doctor and the fees to compensate him for these services are matters concerning my doctor and me. I understand that I have the primary duty and obligation to pay my doctor for his services, notwithstanding any contract I may have with any third party (be it an insurance company, employer, union, government or the like). Neither my doctor nor I will permit any third party to determine what medical services I need or what fees the doctor should receive in return for these services. Any agreement that either of us may have with any third party shall not affect our doctor-patient relationship and the decisions relating to medical care and fees. Neither my doctor nor I, as his patient, are in any way bound by any contract the other may have with any third party.

Resolution 73M-9

Introduced by: Morgan M. Meyer, for the DuPage County Medical Society
Subject: Model Health Insurance Plan
Referred to: Reference Committee on Economics, Peer Review, Social and Medical Services

WHEREAS, some health insurance plans are completely inadequate to afford reasonable coverage to a patient; and

WHEREAS, other carriers write plans which verge on the point of fraudulence therefore be it

RESOLVED, that the Illinois State Medical Society urge the American Medical Association to write a model health insurance plan which is realistic and reasonable in its provisions; and be it further

RESOLVED, that such model plan be distributed nationally to medical societies, carriers, governmental agencies which control insurance carriers and the public in order that they all be informed what health insurance plans should be.

Resolution 73M-10

Introduced by: John S. Hyde, for Study Committee of the Council on Environmental and Community Heatlh

Subject: Response to Resolution 72M-20—Study of the Getting Report

Referred to: Reference Committee on Environmental, Community and Mental Health

WHEREAS, **Resolution 72M-20** urged the Illinois State Medical Society to study Dr. Vlado Getting's report on public health conditions in Illinois; and

WHEREAS, this resolution was referred to the Council on Environmental and Community Health for its study and recommendations; and

WHEREAS, the Council has studied Dr. Getting's report; and

WHEREAS, the Council feels health services should primarily be provided by local health agencies, or within regions, rather than by the state health agency; and

WHEREAS, the present tax supported governmental health agencies should be consoldated at district levels to promote program stability and relate resources and distribution of professionals near the tax base; and

WHEREAS, present local health service jurisdictions should be consolidated into larger geographic and population districts to achieve program efficiency; and

WHEREAS, the Council agrees that if left alone the Getting Report would probably be shelved and forgotten;

RESOLVED, that the Illinois State Medical Society urge the Department of Public Health to give serious consideration to implementing recommendations contained in the Getting Report.

All members are urged to participate in the—

REFERENCE COMMITTEE MEETINGS

Sunday, March 25 **7:00 p.m.**

Officers and Administration Room 413

Amendments to Constitution & Bylaws Room 418

Finances, Budgets and Publications Room 419

Governmental Affairs, Medical-Legal Room 2

Education and Manpower Room 4

Economics, Peer Review, Social & Medical Services .

(to be announced)

Public Relations, Membership and

Miscellaneous Business Room 3

Environmental, Community and Mental Health . Room 415

Special Reference Committee No. 1 (Open Forum) . (to be announced)

Program Summary By Days

(Preliminary)

Saturday
March 24, 1973

9:00 a.m.	IFMC Board Meeting
2:00 p.m.	ISMS Board of Trustees Meeting

Sunday
March 25, 1973

8:30 a.m.	Delegates Registration
9:30 a.m.	PSRO Conference
12:30 p.m.	ISMS District Caucuses
1:30 p.m.	Illinois Society of Anesthesiologists, Inc. & Chicago Society of Anesthesiology
1:30 p.m.	Chicago Pediatric Society
2:00 p.m.	Chicago Urological Society
3:00 p.m.	House of Delegates
5:30 p.m.	Delegates Buffet
7:00 p.m.	Reference Committees—
	Special Reference Committee #1 (Open Forum)
	Constitution & Bylaws
	Officers & Administration
	Finances, Budgets & Publications
	Governmental Affairs & Medical Legal
	Education & Manpower
	Environmental, Community & Mental Health
	Economics, Peer Review, Social & Medical Services
	Public Relations Membership & Miscellaneous Business

Monday
March 26, 1973

8:00 a.m.	Registration Opens
	Illinois Surgical Society
8:30 a.m.	Board of Trustees Meeting
9:00 a.m.	American Medical Writers Association
	Chicago Heart Association
	Chicago Gynecological Society
	National Training Center on Drug Abuse
9:30 a.m.	Illinois Society of Internal Medicine
1:00 p.m.	Chicago Society of Internal Medicine
1:30 p.m.	Chicago Ophthalmological Society & Illinois Association of Ophthalmology
4:00 p.m.	IMPAC Annual Meeting
6:00 p.m.	U. of Illinois Alumni Association Dinner

Tuesday
March 27, 1973

8:00 a.m.	Public Affairs Breakfast
	Board of Trustees Meeting
	Registration Opens
9:00 a.m.	Chicago Neurological Society
	Chicago Rheumatism Society
	Chicago Society of Gastroenterology
11:00 a.m.	Chicago Society of Allergy
12:00 noon	Fifty-Year Club Luncheon
1:30 p.m.	American College of Chest Physicians
2:00 p.m.	House of Delegates
2:00 p.m.	Chicago Surgical Society & Chicago Radiological Society
6:00 p.m.	President's Night

Wednesday
March 28, 1973

8:00 a.m.	Registration Opens
8:30 a.m.	Board of Trustees Meeting
9:00 a.m.	Chicago Dermatological Society
	Chicago Pathological Society & Illinois Pathological Society
	Chicago Orthopedic Society & Chicago Committee on Trauma of American College of Surgeons
	American Association of Medical Assistants, Inc., Chicago Chapter
	Instruction Course in Medicine
12:30 p.m.	Chicago Laryngological & Otological Society
1:15 p.m.	Chicago Society of Plastic Surgery
	Diabetes Association of Greater Chicago
2:00 p.m.	House of Delegates
6:00 p.m.	Board of Trustees Dinner

Physicians and Auxillary of

the Illinois State Medical Society

are cordially invited to a complimentary

Public Affairs Champagne Brunch

8:00 a. m. Tuesday

March 27, 1973

Boulevard Room

Conrad Hilton Hotel

Mrs. Robert Hart, Pulse Editor

WA/ISMS

"Getting to Know You" Conference

March 25-28, 1973 Conrad Hilton Hotel, Chicago

Registration

(Lower level of Conrad Hilton)

Sunday, March 25, 10 a.m.-5:30 p.m.
Monday, March 26, 8:30 a.m.-5:30 p.m.
Tuesday, March 27, 8:30 a.m.-5:30 p.m.
Wednesday, March 28, 8:30 a.m.-11 a.m.

all tickets for social events available at registration)



Mrs. Ralph (Angela) White, Convention Chairman

Highlights of the Conference

Sunday, March 25

Pin and Gavel Brunch: 12 noon
Pre-Convention Board Meeting, 2-4 p.m.
Social Hours: 11:30 a.m. to 12:30 p.m.
Sherry Party: 5-6 p.m. at the Hospitality Suite
Board Dinner: 7 p.m., Playboy Penthouse
(Husbands, wives, guests are all welcome to attend)

Monday, March 26

Convention sessions: 9 a.m.
"Getting to Know You" Luncheon: 12:30 p.m. Boulevard Room
Honoring Mrs. August Martinucci, President, WA/ISMS and Mrs. Robert Beckley, WA/AMA
High Tea: 4 p.m.

Honoring Mrs. Willard Scrivner, President-elect, WA/AMA

Evening free—anyone desiring tickets to the theater, or the Renoir art exhibit, or a shopping trip should contact Mrs. Ralph white, 1101 Kenilworth, Oak Park

Tuesday, March 27

Complimentary Public Affairs Champagne Brunch: 8 a.m.

Convention session: 10 a.m.

Memorial Musical Program: Honoring the deceased auxiliary members; featuring Sue Carter Harp, sololist and well-known Chicago harpist.

Getting to Know the County Presidents: 10:30 a.m.

"To the Stars Through Your Aspirations" Luncheon: 12:30 p.m., Boulevard Room

Honoring Mrs. Robert Hartman, President-elect, WA/ISMS

Program will be presented by noted Katherine de Jersey on "Follow Your Lucky Stars."

President's Night: Reception 6 p.m. Dinner 7 p.m.

Honoring ISMS President Frank J. Jirka, Jr., Mrs. Jirka and the Woman's Auxiliary

Entertainment provided by: Franz Benteler, His Stradivarius & Violins in Concert

Dress is optional



Welcome From the President

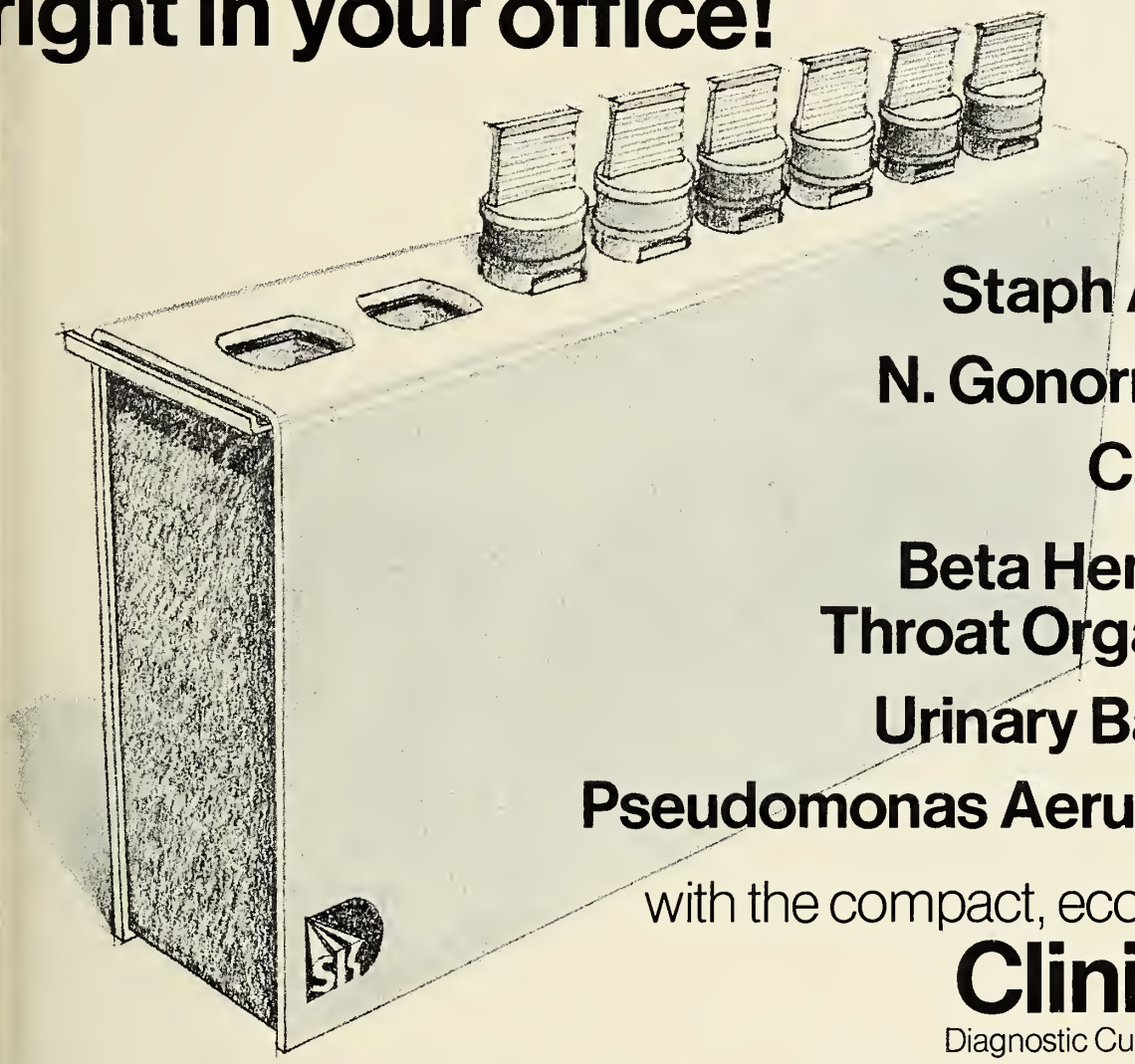
This is a time to review the year's progress and project on the goals for the next. We have gleaned information and know-how to spark enthusiasm for you to take back to your membership and community.

You are invited to be a part of our changing times in the programs of health education and the new frontiers in the legislation of medicine. Challenge yourself to find out how much one person can really undertake.

So, make the most of this opportunity to learn, to exchange ideas and to be entertained all blended with conviviality that encourages new friendships while strengthening old ones. Do have a happy time, and it was wonderful "getting to know you."

Mrs. August Martinucci,
WA/ISMS *President*

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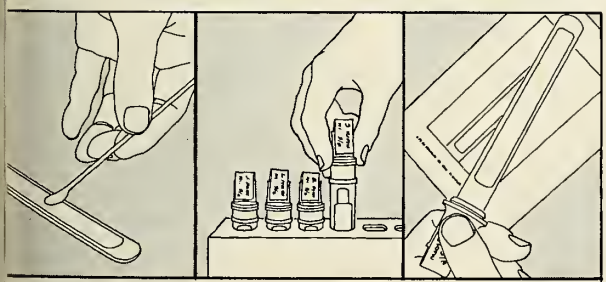
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editorials

Physician's Fees

The following is an interesting comment on priorities. A woman called a plumber to repair a leaking faucet. Since it was not an emergency, the man came a few days later. In a matter of minutes, the faucet was fixed. "How much?" asked the woman. "Twenty-five dollars" said he. "Twenty-five dollars!" exclaimed the woman, "my pediatrician does not charge that much for a house call." To this the plumber replied, "How well I know, I used to be a pediatrician."

Providers of medical care frequently take the rap for being expensive, but by comparison, physician fees are not as high as those of many lawyers, executives, or skilled workers. Doctors are not "wanting" or crying poor mouth, and we realize that many make a comfortable living. As a rule, however, material gains are the result of long hours, daily and on week-ends and holidays. In addition, they spend very little time on luncheons and dinners. Physicians are on call when attending church, the theater, and athletic events. But despite all of this, the average American spends far less on physicians' fees than he has been led to believe.

Medical care is not too expensive when compared to the cost of maintaining the family car. Each year, the average American spends almost twice as much on his automobile than he does on his body. He spends three times as much on food, housing, and household expenditures.

Americans also profess extreme interest in their health. Yet, annually, they spend almost $10 billion on tobacco and $15.5 billion on alcoholic beverages. To this we can add $33.5 billion for recreation. The concern over medical bills becomes a question of priorities. No one enjoys being sick and people hate even more having to pay for something they hate. ◄

T. R. Van Dellen, M.D.
Editor

Thomas R. Wilson: *Quality Medical Care,* Selected Papers of the Carle Clinic and Carle Foundation 25.2 (July) 1972, pgs. 49-55.

report

a service of the american association of medical assistants, illinois society

An Invitation to All Medical Assistants of Illinois

COME...Open to all medical assistants and physicians
Wednesday - March 28, 1973
MIDWEST CLINICAL
CONFERENCE
MEDICAL ASSISTANT PROGRAM
Conrad Hilton Hotel, Chicago

Why Attend?... It's educational, professional, informative and instructive. . . . So necessary in the medical health picture that the Illinois State Medical Society and The Chicago Medical Society have included the MA. in their program for the Clinical Conference for the past three years. You'll learn from the interesting program and enjoy the friendliness, cheerfulness and good fellowship of other medical assistants.

Who Attend?... Doctors and medical assistants throughout Illinois. The American Association of Medical Assistants, Illinois Society invites you to COME — LISTEN — LEARN.

The Program:

9:00 A.M. Welcome by *Mrs. June Hall, President,* AAMA-Illinois Society
"The Pediatrician and the Medical Assistant," *Oliver Crawford, M.D.,* President, Chicago Pediatric Society

10:30 A.M. "Child Abuse"—Panel Discussion
Rowine Hayes Brown, M.D., Associate Director, Pediatrics, Cook County Hospital
James H. Ryan, M.D. Kankakee, Pediatrician, and Coroner of Kankakee County. Author of "Suffer The Little Ones"
Lois Wille, Pulitzer Prize Winner Journalist, *Chicago Daily News*
Mrs. Zelma Bechtol, Moderator, Secretary-Treasurer, AAMA

12:30 P.M. Luncheon

1:30 P.M. "The Alphabet Game"
Mrs. Rochelle Freeman, Sales and Service Coordinator, Foster-Western Lab., Inc.

2:00 P.M. "Statewide Emergency Care"
David R. Boyd, M.D., Chief, Emergency Health Services, Illinois Department of Public Health

2:45 P.M. "The Headache Clinic," *Seymour Diamond, M.D.*

To Register:
(fill out form; cut along this line; mail TODAY!)

Send to MRS. LUELLA MITCHELL, 7920 South Eberhart, Chicago 60619

I will attend A.M. Session; Luncheon; P.M. Session; ALL DAY

FEE $7.00

NAME **Member AAMA** **Yes** **No**

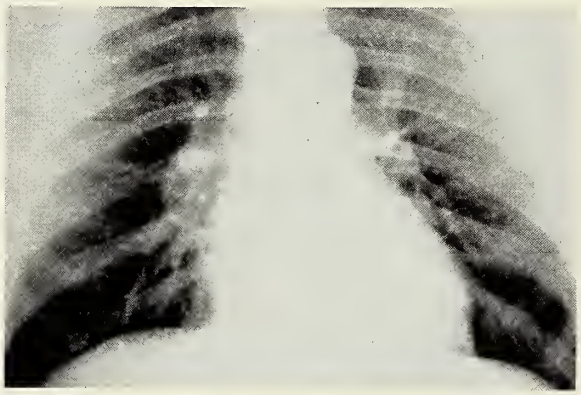
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CITY **COUNTY** **ZIP**

REGISTRATION DEADLINE: MARCH 19, 1973

the view box

Leon Love, M.D./Chairman/Department of Radiology
Loyola University Stritch School of Medicine



This 23-year-old female had a routine chest examination. Clinically the patient was able to approximate her shoulders anteriorly.

What's your diagnosis?

(Answers on page 192)

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All Mudranes are bronchodilator-mucolytic in action, and are indicated for symptomatic relief of bronchial asthma, emphysema, bronchiectasis and chronic bronchitis. **MUDRANE tablets** contain 195 mg. potassium iodide; 130 mg. aminophylline; 21 mg. phenobarbital (Warning: may be habit-forming); 16 mg. ephedrine HCl. **Dosage** is one tablet with full glass of water, 3 or 4 times a day. **Precautions** are those for aminophylline-phenobarbital-ephedrine combinations. **Iodide side-effects:** May cause nausea. Very long use may cause goiter. Discontinue if symptoms of iodism develop. **Iodide contraindications:** Tuberculosis; pregnancy (to protect the fetus against possible depression of thyroid activity). **MUDRANE-2 tablets** contain 195 mg. potassium iodide; 130 mg. aminophylline. **Dosage** is one tablet with full glass of water, 3 or 4 times a day. **Precautions** are those for aminophylline. **Iodide side-effects and contraindications are listed above. MUDRANE GG tablets** contain 100 mg. glyceryl guaiacolate; 130 mg. aminophylline; 21 mg. phenobarbital (Warning: may be habit-forming); 16 mg. ephedrine HCl. **Dosage** is one tablet with full glass of water, 3 or 4 times a day. **Precautions** are those for aminophylline-phenobarbital-ephedrine combinations. **MUDRANE GG-2 tablets** contain 100 mg. glyceryl guaiacolate; 130 mg. aminophylline. **Dosage** is one tablet with full glass of water, 3 or 4 times a day. **Precautions:** Those for aminophylline. **MUDRANE GG Elixir.** Each teaspoonful (5 cc) contains 26 mg. glyceryl guaiacolate; 20 mg. theophylline; 5.4 mg. phenobarbital (Warning: may be habit-forming); 4 mg. ephedrine HCl. **Dosage:** Children, 1 cc for each 10 lbs. of body weight; one teaspoonful (5 cc) for a 50 lb. child. Dose may be repeated 3 or 4 times a day. Adult, one tablespoonful, 4 times daily. All doses should be followed with ½ to full glass of water. **Precautions:** See those listed above for Mudrane GG tablets.

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First choice

MUDRANE-2
When ephedrine is too exciting or is contraindicated

MUDRANE GG
During pregnancy or when K.I. is contraindicated or not tolerated

MUDRANE GG-2
A counterpart for Mudrane-2

MUDRANE GG ELIXIR
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practice management

"Winners Pay Losers" In Insurance Game

By Frank Pawlowski, Consultant
Professional Business Management/Deerfield

Insurance has been defined as a system whereby those who avoid a loss (the winners) pay to those who do suffer damage (losers). The insureds who are lucky enough not to sustain a financial or physical loss contribute by premium payments to the unlucky one who do have a loss. If you never collect from your property insurance policy, consider yourself ahead. However, if you do have a claim for an insured loss, you have the security of knowing that the other insurance policy owners will compensate for most of your burden. Your premiums are the price you pay for freedom from worry about economic loss beyond your control.

Insurance itself becomes a subject of worry for many doctors we counsel in our capacity as business consultants. To help you lessen this worry, there may be ways of bolstering your insurance program that have not occurred to you.

The initial step to take is to formulate your insurance program. A sensible insurance protection plan is as important to a sound business as proper financing, personnel management, fee collection, business management or any other business operation. Like these functions, good risk management is attained by organization and planning. Years of work and goals can be lost quickly if your insurance portfolio does not include certain elements. To ensure that you have the proper security, the following four steps should be undertaken:

1. Know the ways you can suffer loss.
2. Organize your insurance management program.
3. Buy adequate coverage economically.
4. Get professional advice.

Recognize the Risks

Some businesses will need special coverages not essential to others; as, for example, doctors should carry malpractice and umbrella liability risk protection.

Study Insurance Costs

Before buying any policies, check the methods which enable you to lower the costs of your insurance by employing these points: 1) cover your largest risk first; 2) make use of deductibles; 3) avoid overlapping coverages; 4) purchase as large a "package" policy as possible; and 5) review your program periodically for adequacy and savings.

Have a Plan

A definite insurance outline will be a solid basis for the objectives of your practice.

Here are some suggestions for adequate management:

a) Set down what you expect insurance will do for your business.
b) Select one knowledgeable agent to handle your portfolio.
c) Make one person responsible for this program.
d) Try to prevent losses or keep them as low as possible.
e) Do not underinsure.
f) Keep complete records.

(Continued on page 192)

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new pharmaceutical specialties

by paul dehaen

For detailed information regarding indications, dosage, contraindications and adverse reactions; refer to the manufacturer's package insert or brochure.

Single Chemicals—Drugs not previously known, including new salts.

Duplicate Single Drugs—Drugs marketed by more than one manufacturer.

Combination Products—Drugs consisting of two or more active ingredients.

New Dosage Forms—Of a previously introduced product.

The following new drugs have been marketed:

SINGLE CHEMICALS

GEOCILLIN Penicillin Derivative ℞
Manufacturer: J. B. Roerig, Div. Pfizer Pharmaceuticals
Nonproprietary Name: Carbenicillin Indanyl Sodium
Indications: Acute and chronic infections of the upper and lower urinary tract.
Contraindications: Patients with known penicillin allergy
Warning and Precautions: See Package Insert
Dosage:

Bacteria	Acute	Chronic
E Coli	1 tab. q.i.d.	1-2 tab. q.i.d.
Proteus mirabilis	1-2 tab. q.i.d.	1-2 tab. q.i.d.
Pseudomonas	2 tab. q.i.d.	2 tab. q.i.d.

Supplied: Tablets, equivalent to 382 mg of carbenicillin

PAVULON Skeletal Muscle Relaxant ℞
Manufacturer: Organon, Inc.
Nonproprietary Name: Pancuronium Bromide
Indications: Adjunct to anesthesia to induce skeletal muscle relaxation. May also be employed in patients undergoing mechanical ventilation.
Contraindications: Hypersensitivity to the drug and the bromide ion.
Warnings: Administration requires careful supervision by experienced clinicians.
Dosage: Must be carefully adjusted; for details see package insert.
Supplied: Ampuls 2 and 5 cc., 2 mg./cc.

DUPLICATE SINGLE DRUGS

CENTET Antibiotic ℞
Manufacturer: Central Pharmacal
Nonproprietary Name: Tetracycline HC1
Indications: Tetracycline susceptible infections
Contraindications: Hypersensitivity to tetracyclines
Precautions Those usual for antibiotics
Dosage: Daily average 1-2 gm. divided in 2 or 4 equal doses, depending on severity.
Supplied: Capsules 250 and 500 mg.

M-R-VAX Measles and Rubella Virus Vaccine ℞
Manufacturer: Merck Sharp & Dohme, Div. Merck & Co., Inc.
Composition: Measles and Rubella Virus Vaccine, Live
Indications: Immunization against measles and rubella in children from one year of age to puberty.
Contraindications: See package insert.
Precautions: Do not give intravenously but subcutaneously only.
Dosage: 0.5 cc. of reconstituted vaccine, given by jet injector or syringe.
Supplied: Single dose vial
10 dose vial
50 dose vial

NEW DOSAGE FORMS

CODIMAL Tablets Cold Preparation ℞
Manufacturer: Central Pharmacal
Composition:

Phenylephrine HC1	5 mg.
Chlorpheniramine maleate	2 mg.
Acetaminophen	150 mg.
Aminoacetic acid	150 mg.
Caffeine anhydrous	15 mg.

Indications: Symptomatic relief of the common cold
Dosage: Adults: 1 or 2 tablets q.i.d.
Children: 6 yrs. or over ½ to 1 tablet q.i.d.
Supplied: Tablets

OMNIPEN Pediatric Drops Antibiotic ℞
Manufacturer: Wyeth Laboratories
Nonproprietary Name: Ampicillin
Indications: Infections caused by susceptible strains: shigella, salmonella and others.
Contraindications: Patients with known penicillin allergy.
Dosage:

Respiratory Tract Infections:	(in equally divided doses) 50 mg./kg./24 hrs.
G.I. Tract Infections:	100 mg./kg./24 hrs.
Urinary Tract Infections:	100 mg./kg./24 hrs.

Supplied: Bottles 20 cc., 100 mg./cc. ◄

Doctor's News

PHYSICIANS NO LONGER HAVE TO POST PRICE SCHEDULES—In the first Phase 3 regulations issued by the Cost of Living Council, published in the *Federal Register* Jan. 12, the requirement was lifted that health care providers, including institutions and physicians, must post base prices. Only the posting requirement is lifted, the council noted; price adjustments by providers "remain subject to the classification, prenotification, and reporting requirements of the Council and the rules and regulations of the Price Commission in effect on Jan. 10, 1973."

PSRO IMPLEMENTATION MORATORIUM—At the first meeting of the AMA Advisory Committee on Professional Standards Review Organizations, a moratorium on PSRO implementation by state and county medical societies was proposed. The 23-member committee agreed that this is necessary since there is no national administrator of the PSRO program and no national guidelines for establishing PSRO.

Dr. Joseph R. O'Donnell, ISMS Trustee, has been appointed to serve on this advisory committee.

"MEDICARE MISCONCEPTIONS" REVISED—The booklet, "Medicare Misconceptions," has been updated and revised. It is available for distribution to physicians, hospitals and other institutions. In quantities of ten or less they are free, two-cents for each copy over ten, available in quantities of 250 or more. Contact the Public Relations Division, ISMS, 360 N. Michigan Ave., Chicago, 60601.

ICCME CURRENT ACTIVITIES—Reported in last month's Doctors News was a listing of possible future activities of the Illinois Council on Continuing Medical Education. The following is a synopsis of the immediate operational goals for ICCME:

1. *Logistics, manpower, and resources:* Establish a map of the State outlining hospitals, medical societies, number of physicians, and other information pertinent to our goals in a master plan in the Illinois State Medical Society.

2. *DME Meetings:* Organize quarterly (or as often as those interested should desire) meetings of hospital DME's and others interested, in various parts of the State, for exchange of ideas and information.

3. *CME Workshop:* Present a one-day workshop, Autumn, 1973, for ICCME Board, hospital DME's, and others, on techniques of planning adult learning experiences, to be offered twice or more, in various locations, as interest indicates.

4. *Consultation:* Offer consultation with hospitals, county medical societies, state specialty societies, and others on CME methods. Telephone or written inquiries, no charge; personal visits of half-day or longer, charge at fee to be determined. Such consultation might include workshops for staff on planning CME.

5. *CME Calendar:* Maintain a central calendar of all CME activities in the Midwest, aiming to help DME's and others co-ordinate activities to avoid needless duplication.

6. *Periodical Guide:* Offer to assume responsibility for "What Goes On, A Guide to Continuing Education" in the *Illinois Medical Journal,* to include (a) all upcoming formal CME courses in selected Midwestern states, as well as information on other learning opportunities, and (b) a coupon

inviting ISMS members to suggest CME learning activities; the coupon will also be made to the *Illinois Osteopath Newsletter.*

7. *Personal Learning Plan:* Publish a pamphlet "Planning Your Personal Learning Program" for physicians. Content would include (a) information on availability of learning opportunities and where to get specifics, and (b) a set of worksheets to assist the individual in thinking through his own learning goals.

8. Plans for the first annual Illinois *CME Congress.* However, this project is pending Board approval.

PHYSICIANS IN THE NEWS—**David Presman, M.D.,** Chairman of Urology, Department of Surgery at Michael Reese Hospital and Medical Center, was elected president of the institution's 550-member medical staff. President-elect is **Lloyd Teitelman, M.D.,** general surgeon and **Gerald Sobel, M.D.,** internist, is secretary-treasurer.

Elected as officers of the medical staff at St. Francis Hospital, Evanston are: **Drs. Donald J. Maylahn,** Skokie, president; **John W. O'Donnell,** Evanston, president-elect and **Bert T. Heffernan,** Evanston, secretary-treasurer.

William Dalessandro, M.D., and **Mario Feola, M.D.,** both from Chicago, have been named as Fellows of the American College of Cardiology.

Chicago Lakeshore Hospital, a private psychiatric hospital, elected **Drs. Katharine Wright** president of the medical staff, **Isadore Finkelman,** vice-president and **Bernard Rattner,** secretary.

REQUIREMENTS ON BLOOD—All owners/operators of establishments including hospitals that engage in the collection, manufacturing, preparation, propagation, compounding, or processing of human blood or blood products are required to register with the Food and Drug Administration before April 3, 1973. Registration forms are available from the Bureau of Biologics (BI-7), Food and Drug Administration, 5500 Fishers Lane, Rockville, Md. 20852, or at any FDA district offices. Completed forms should be mailed to Blood Bank Registration (BI-7), Bureau of Biologics, Food and Drug Administration, at the above address. The regulation was published in the Jan. 31 *Federal Register.*

Pfizer Labs Present Donations To ISMS



Mr. Don Simcoe (right), Manager of Regional Health Services, Pfizer Labs, presents two checks to the ISMS Educational and Scientific Foundation to assist in distribution of education material about venereal diseases. Also donated were 12,000 pocket rulers with a VD message imprinted for distribution to the ISMS membership. Looking on is Richard A. Ott, Director of Scientific Services as Richard Hengl, Business Manager, receives the materials.

Drs. Palmer and Freedman Receive Scientific Achievement Awards



Walter L. Palmer, M.D. and Daniel X. Freeman, M.D., were among the ten medical educators and researchers who received 1973 Awards for Distinguished Achievement from **Modern Medicine** medical journal.

Dr. Palmer, a Richard T. Crane Professor of Medicine Emeritus at the University of Chicago, was cited "for a lifetime of significant achievement in clinical gastroenternology and leadership in medical education."

Dr. Freeman, a Louis Block professor of biological sciences at the University of Chicago, received citation for his work in psychopharmacology.

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Pheniramine maleate 7.5 mg.
Codeine phosphate 10.0 mg.
(warning: may be habit forming)
Alcohol, 3.5%

Non-narcotic for 6-8 hr. cough control

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Dextromethorphan hydrobromide 15 mg.
Alcohol, 1.4%

Robitussin-DM in solid form for "coughs on the go"

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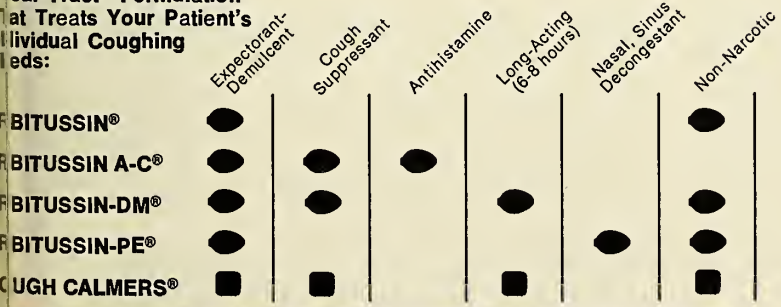
Each Cough Calmer contains:
Glyceryl guaiacolate 50 mg.
Dextromethorphan hydrobromide 7.5 mg.

Relieves cough, clears sinuses and nasal passages—keeps them "drip-dry" but not bone dry

ROBITUSSIN-PE®

Each 5 cc. contains:
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Phenylephrine hydrochloride 10 mg.
Alcohol, 1.4%

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what goes on

a guide to continuing education

February 21-22—The Cleveland Clinic Educational Foundation—American Society for Clinical Pharmacology and Therapeutics

Pharmacology and Clinical Effectiveness of Anti-Inflammatory Drugs

Registration Fee: $60.00
Contact: The Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland, OH 44106

Bunts Auditorium, Cleveland

February 28-March 1—The Cleveland Clinic Educational Foundation

Sports Medicine

The Cleveland Clinic is pleased to offer a postgraduate course in Sports Medicine. This course will be presented by staff members of the Cleveland Clinic Foundation and by several guest speakers.
Registration fee: $60.00
Contact: The Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland, OH 44106

Bunts Auditorium, Cleveland

March 5—The University of Illinois

Course in Laryngology and Bronchoesophagology

The Abraham School of Medicine at the University of Illinois will conduct a continuing education course in Laryngology and Bronchoesophagology. The course is limited to fifteen physicians and will be under the direction of Paul Holinger, M.D. Instruction will be provided by means of animal demonstrations and practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics, as well as didactic lectures.
Contact: The Department of Otolaryngology, Eye and Ear Infirmary, 1855 West Taylor Street, Chicago 60612

Eye and Ear Infirmary and visits to a number of other Chicago Hospitals

March 9-10—Central States Society of Industrial Medicine and Surgery

Spring Conference

This two-day conference is sponsored in association with the Mental Health Association of Greater Chicago.
Topics for discussion will include a panel presentation on "Rehabilitation of the Emotionally Handicapped Employee," and "Roles of Occupational Medicine in Heart Disease Identification, Prevention, and Follow through."
Contact: Rita Packer, Executive Secretary, 119 Shabbona Drive, Park Forest, Ill 60466.

Pick Congress Hotel, Chicago

March 10-11—American Academy of Pediatrics

Provocative Allergy Course

This will be a practical course in the technique of intradermal food testing and food injection therapy.
It also will cover inhalants, chemicals, drugs, fungi, yeast, viruses, hormones, terpenes, air-pollutants, insects, and contact dermatitis.
Registration: $125.00
Contact: Joseph B. Miller, M.D., 3 Office Park, Suite 110, Mobile, Alabama 36609

Admiral Semmes Hotel, Mobile, Alabama

March 14—Martha Washington Hospital

"Hyperthyroidism"

This is the Martha Washington Hospital Second Annual Lecture. The Lecture will be given by Sheldon S. Waldstein, M.D. of Northwestern University.
Contact: Fernando Lopez-Fernandez, M.D., Medical Director, Martha Washington Hospital, 2318 Irving Park Road, Chicago, Illinois 60618.

Holiday Inn—Chicago O'Hare International Airport, 3801 North Mannhein Road, Schiller Park

March 15-16—The University of Texas Medical Branch

The 22nd Annual Postgraduate Course in Pediatrics

The course will emphasize "Problems of Office Pediatrics," with guest lecturers Victor C. Vaughan, III, M.D., and John B. Reinhart, M.D.
This program is acceptable for 12 prescribed hours by the American Academy of Family Physicians.
Registration: $75.00
Contact: Lillian H. Lockhart, M.D., Chairman, Pediatric Postgraduate Committee, The University of Texas Medical Branch, Galveston.

Galveston, Texas

March 16-17—Epilepsy Center of Michigan

"Epilepsy '73': a Multidisciplinary Symposium on Current Developments"

This will be a two-day symposium/workshop to be held in Detroit, with the following internationally-known authorities on epilepsy:
"Advances in the Medical Surgical Treatment of Epilepsy," Joseph Wilder, M.D., A. Earl Walker, M.D., J. Kiffen Penry, M.D., and J. Gordon Millichap, M.D.
"Progress in Psychosocial Treatment and Understanding in Epilepsy," Manfred Meier, Ph.D., George J. Goldin, Ph.D., Frank Risch, Ph.D. and Janice R. Stevens, M.D.
Contact: Epilepsy Center of Michigan, 10 Peterboro, Detroit, MI 48201

David Whitney House, Detroit

March 25-28—Illinois State Medical Society and Chicago Medical Society

Midwest Clinical Conference and the Illinois State Medical Society Annual Meeting

ISMS and CMS with invited specialty societies will offer scientific sessions and specialty programs; President's Dinner, Public Affairs Breakfast and the House of Delegates.
ISMS members contact: Mr. Perry Smithers, ISMS Office, 360 N. Michigan Ave., Chicago, 60601.

Conrad Hilton Hotel, Chicago

March 29-30—Council on Rural Health American Medical Association

26th National Conference on Rural Health

The theme of the conference is "Rural Health—Innovation to Implementation." The purpose is to explore new needs and report on new developments in Rural Development and Rural Health, Consumer Health Education, Health Science Schools and Rural Health Manpower, National Health Service Corps, Rural Health Systems and the Young Physician, and Community Organization for Rural Health Services, to name only a few.
Registration opens at 8:00 a.m. Thursday.
Contact: American Medical Association, Department of Rural Health, Division of Medical Practice, 535 N. Dearborn St., Chicago, IL 60610, Attention: Bond L. Bible, Ph.D.

Statler-Hilton, Dallas

March 29-31—University of Wisconsin—LaCrosse

Midwest Regional Medical Symposium (Exercise and the Heart) and Physical Fitness Clinic

This conference will feature one day devoted to the medical aspects of physical fitness and two days devoted to the role of the school in physical fitness, including sessions from the view of the Handicapped program, the Elementary program, and the Secondary program.
Clinic fee: $3.00 per person.
Contact: Dr. Clifton De Voll, Associate Dean of HPER, University of Wisconsin—La Crosse, La Crosse, Wisconsin 54601.

University of Wisconsin—LaCrosse

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STARTING DATES—1973

SPECIALTY REVIEW IN PEDIATRICS, April 2
SPECIALTY REVIEW IN NEUROLOGY, Basic, April 2
REVIEW IN NEUROPATHOLOGY, One Week, April 9
SPECIALTY REVIEW IN DERMATOLOGY, April 30
SPECIALTY REVIEW IN OBSTETRICS & GYNECOLOGY, April 30
MANAGEMENT OF COMPLICATIONS IN SURGERY, Four Days, March 6
PRE & POSTOPERATIVE CARE OF PATIENTS, Four Days, March 13
DISEASES OF ESOPHAGUS, STOMACH & DUODENUM, April 5
SURGERY OF GASTROINTESTINAL TRACT, Four Days, April 9
BLOOD VESSEL SURGERY, One Week, March 26
PROCTOSCOPY, SIGMOIDOSCOPY & FIBEROPTIC COLONOSCOPY, Three Days, April 25
BASIC OBSTETRICS, One Week, April 2
BASIC GYNECOLOGY, One Week, April 9
BASIC ELECTROCARDIOGRAPHY, One Week, March 5
BASIC INTERNAL MEDICINE, One Week, March 19
BASIC DERMATOLOGY, One Week, March 26
COMMON GENETIC DISEASES, One Week, May 7
STATE & NATIONAL BOARD REVIEW, Basic, April 29, Clinical May 7
INHALATION & REGIONAL ANESTHESIA, Request Dates

Information concerning numerous other continuation courses available upon request.

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UNITED STATES SAVINGS BONDS

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Twenty-nine Clinics For Crippled Children Listed for March

Twenty-nine clinics for Illinois' physically handicapped children have been scheduled for March by the University of Illinois, Division of Services for Crippled Children. The Division will count twenty-two general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social, and nursing services. There will be six special clinics for children with cardiac conditions, and one for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

March 1 Sterling—Sterling Community Hospital
March 1 Lake County Cardiac—Victory Memorial Hospital
March 1 Effingham—St. Anthony Memorial Hospital
March 6 E. St. Louis—Christian Welfare Hospital
March 6 Carmi—Carmi Township Hospital
March 7 Hinsdale—Hinsdale Sanitarium
March 7 Jacksonville—Norris Hospital
March 9 Chicago Heights Cardiac—St. James Hospital
March 12 Peoria Cardiac—St. Francis Children's Hospital
March 13 Peoria—St. Francis Children's Hospital
March 13 E. St. Louis—Christian Welfare Hospital
March 13 Carrollton—Boyd Memorial Hospital
March 14 Joliet—St. Joseph's Hospital
March 14 Champaign-Urbana—McKinley Hospital
March 15 Macomb—McDonough District Hospital
March 15 Elmhurst Cardiac—Memorial Hospital of DuPage County
March 15 DeCatur—Decatur Memorial Hospital
March 15 Springfield—St. John's Hospital
March 15 DuQuoin—First Methodist Church
March 20 Rock Island—Moline Public Hospital
March 20 Belleville—St. Elizabeth's Hospital
March 21 Evergreen Park—Little Company of Mary Hospital
March 21 Springfield Pediatric-Neurological — Diocesan Center
March 23 Chicago Heights Cardiac—St. James Hospital

(Continued on page 192)

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View Box

(Continued from page 176)

DIAGNOSIS—*Cleidocranial Dysostosis*—In most cases of this disorder, the skull and clavicles are involved but other structures may be affected as well. The skull has a fairly characteristic appearance demonstrating numerous wormian bones. The fontanelles may remain patent for a considerable amount of time. The mandible is prognathous but the maxilla is hypoplastic as are other facial bones.

A major abnormality is deficiency or absence of the clavicles demonstrated on this examination. Because the clavicle ossifies from three centers, any part may be absent so that there are many variations in the appearance of these bones. In the pelvis the bones are often underdeveloped and the symphysis pubis may be unusually wide. The sacrum and coccyx may be malformed or the coccyx may be absent. ◄

Practice Management

(Continued from page 278)

g) Have your property appraised periodically.

Get Professional Advice

Since insurance is a complex and detailed business, a professionally qualified agent, broker, or consultant is a practical necessity.

Some businessmen consider insurance premiums to be a sort of a tax. They know that it is a necessary, but burdensome, expense to be held to a minimum. If you will choose a more constructive viewpoint, you can use insurance for positive advantages. Used properly, insurance can greatly help you succeed in your business operation. It can also provide for peace of mind knowing that all you have worked for, your family, home, and practice, are secure from financial loss. The potential benefits of good insurance management will make it well worth your study and attention. ◄

(Reference: SBA-SMA No. 148)

Clinics For Crippled Children

(Continued from page 191

March 26 Peoria Cardiac—St. Francis Children's Hospital
March 27 Peoria—St. Francis Children's Hospital
March 28 Elgin—Sherman Hospital
March 28 Centralia—St. Mary's Hospital
March 28 Rockford—St. Anthony Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective, and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. ◄

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Maternal Death Case Study No. 10

Edited by Robert Hartman, M.D./Jacksonville

This 30-year-old gravida 8, whose previous pregnancies have been uncomplicated with birth weights ranging from 5½ to 8½ pounds, had not obtained prenatal care until the fifth month of her pregnancy. Following that, her care was somewhat sporadic; however, at no time had there been noted any hypertension, proteinuria, edema, or evidence of systemic disease. Her labor began about noon and approximately one hour later her membranes ruptured. Eighty minutes later, she delivered a normal baby weighing 7 pounds 8 ounces over an intact perium under penthrane, Nitrous oxide, and oxygen anesthesia.

Forty-eight hours post partum, she spiked a fever of 102.8. No positive findings were noted on physical examination, and she was started on Tetracycline. Urinalysis was negative. Her white count was 10,600 with a normal differential. The following morning, she had some distention; however, her temperature was 102.8. Two hours later, her temperature was down to 97, and she was given an enema with no results. Against the advise of her physician, she was allowed to sign herself out of the hospital. Five days later, she was readmitted in extremis and died within an hour of admission.

A post mortem examination revealed an acute endometritis with parametritis and a purulent peritointis. Blood cultures and uterine cultures were positive for E coli.

Your committee felt that this death was directly obstetrical due to infection with preventable factors. That the patient may have contributed to her demise is incontrovertible, but the fact that she was allowed to do so is an indictment against medicine. It is the feeling of your committee that every physician must become that from which his name originates, "teacher." It is our responsibility to continue to preach the gospel of good prenatal care, and to so conduct ourselves that our patients can trust implicitly our advice. In this particular incident, it seemed unfortunate that no attempt was made to isolate the offending organism, no blood cultures or intrauterine cultures were taken prior to primary discharge. Further, there is no good evidence that strong efforts were made to dissuade the patient from leaving the hospital.

There is a tendency, constantly to be guarded against, when patients are poorly educated and uncooperative, to wash one's hands of them. These patients require more time, more understanding, and more effort. But given these, tragedies such as the one described above, can often be prevented.

Obituaries

*Bucher, E. C., Gibson City, died at the age of 64 on December 12. Dr. Bucher served as president of the Ford County Medical Society for three terms; was delegate to the Illinois State Medical Society for four years; a member of the Illinois Obstetrical and Gynecology Society since 1948 and was also councilor of the 11th district. From 1952 to 1954 he served as chief of staff of Gibson Community Hospital. In 1968 he was elected president of the board of directors of the Illinois Medical Alumni Association and was a member of the University of Illinois Foundation.

**Carpenter, Morgan G., died at the age of 73, on November 18. Dr. Carpenter was a general surgeon and family physician. He also served on the staff of St. Joseph Hospital and was past president of Sherman Hospital. Dr. Carpenter was also honored by ISMS as a physician practicing for 50 years.

**Chouinard, C. Robert, Oak Park, died at the age of 82 on December 11. Dr. Chouinard was a medical officer during World War I and was the founder of Franklin Boulevard Hospital. He was a physician for more than 50 years.

*Crain, R. Carter, California, died at the age of 78 on October 22. Before his retirement, Dr. Crain practiced in Chicago for 45 years.

*Edwards, Clarence, Libertyville, died at the age of 74, in December, 1972. He was a physician for more than 40 years and past president of the Lake County Medical Society.

*Gaetano, Charles, Oak Forest, died December 1. He maintained offices on the Southwest side. Aware that his illness was terminal, he kept a diary categorizing his reactions, diagnosis and response to medications. His findings and notes will be turned over to the Cancer Research Centers.

**Hyslop, Robert J., Freeport, died November 23. Dr. Hyslop was chief of staff at the local hospital for 11 years. He was a past president of the Stephenson County Medical Society and taught nursing courses in Freeport during his long career. Upon his retirement in 1969, he was honored by the Illinois State Medical Society for 50 years of medical practice.

*Krill, Alex E., Chicago, died at the age of 44 in a jet crash on December 8, 1972. He was returning from Washington where he lectured that morning at the National Eye Institute. He was a professor of Opthalmology at the Pritzker School of Medicine, the University of Chicago.

*Lally, John M., Chicago, died at the age of 64 on October 23. He had been in practice for 35 years during which time he was a founding member of Resurrection Hospital in Chicago.

*Monaco, Joseph, Oak Park, died at the age of 60 on December 5. Dr. Monaco had been in practice for 30 years and was on the staff of St. Anne Hospital.

Neal, John W., LL.B., Arlington Heights, died Dec. 22, aged 58. He was an authority on hospital law and was a partner in the loop law firm of O'Keefe, Ashenden, O'Brien and Hanson. He was former executive administrator and general counsel of the Chicago Medical Society; general counsel of the Illinois State Medical Society and treasurer of the Cook County Graduate School of Medicine.

*Pliura, Vytautas K., died at the age of 52 on November 20. Dr. Pliura served as house physician at the Robinwood St. Luke Hospital, Toledo, Ohio. He also served on the staff of Anna State Hospital.

*Rabinowitz, Yale, Clarendon Hills, died at the age of 54 on December 7. He was the director of cell research laboratory at Hines hospital, and was associate professor of medicine at Loyola University. He pioneered in the development of methods for the separation and purification of human white blood cells, methods which have been used by innumerable investigators throughout the world for a wide variety of research projects.

**Raymond, Charles, died at the age of 84 on November 10. Dr. Raymond, a staff member at Walther Hospital, was a 1916 graduate of Loyola Medical School.

Scheman, Louis, died on November 3, at the age of 64. He was a professor of orthopedic surgery at the Chicago Medical School.

*Solander, Carl K., Chicago, died December 22. He was a member of Cook County General Hospital Unit, and author of several articles. ◄

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Physician Recruitment Program

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program. This is a free service to all physicians.

Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 360 North Michigan, Chicago 60601.

ALBION: General Practitioner. Population 1,800, trade area 13,000 with only 4 physicians in area. Office facilities, financial assistance available. Rural setting, county seat town, expandng economy, hospitals nearby. City Park, swimming pool, tennis courts, etc. Unit school district, Community College 15 minutes. Contact: Don Broster, Citizens National Bank, Albion, 62806, 618-445-2344. (4)

AVON: General Practitioner. Population 1000, trade area 3500 to 4000. Rural practice. Twenty-four bed hospital in town. Office facilities available. Recreational facilities nearby. Excellent area in which to practice and raise a family. Contact: Fred L. Janes, Avon, 61415, 309-465-3883. (4)

BUNKER HILL: Population 2,000 friendly community. Opening for general practitioner. Five hospitals within a 30 mile area. No recreational facilities, but we need you. Surrounding country practice. Contact: Frances S. Stadelman, 110 W. Warren St., Bunker Hill, 62014, 618-585-4565. (5)

BUSHNELL: General Practitioner. Where a doctor can have a family life. Population 3,800. Literally minutes from stocked lakes, water sports. Good hunting. Your dream home costs less. State University close by. Our doctor did Europe all September. Visit there, come home here. Contact: Jack Gordon, Box 150, Bushnell, 61422. 309-772-3141. (4)

CARBONDALE: 25 man multi-specialty in southern Illinois needs Internists, Dermatologist, OB-GYN, Family Practitioners. Generous salary and fringe benefits, early partnership. New, modern building. Developing medical school. Contact: Wayne Given, P.O. Box 1030, Carbondale, 618-549-5311. (4)

CARROLLTON: You can't match or beat the medical opportunities in Greene County, for a Family Physician. Group practice being set-up in a new office building near hospital. For further information write or phone: Drs. Caselton or Wilson or Ray Shoemaker, Carrollton, 62016, 217-942-6946. (4)

CANTON: Urologist and Pediatrician needed by 12-man multi-specialty group. Aggressive city of 15,000 thirty minutes from Peoria. Excellent starting salary leading to full share in corporation. Tax savings and pension plan. Many recreational activities in area. Contact: S. C. Johnson, Coleman Clinic Limited, 175 S. Main St., Canton, 61520 309-647-0201. (5)

CASEY: G.P. wanted to join Medical Center Staff; lab, X-ray, P.T., remote EKG, IPPB, 2 Observ. Rooms, 2 Emerg. Rooms, 24 hr. Emerg. Ser., call every 4th wkend, 1 wk. day, pleasant community, good schools, numerous churches, exceptional recreational facilities, golf course, country club, airport. Contact: Howard G. Johnson, Casey Medical Center, Box 427 Casey, 62420, 217-932-4061. (4)

CHADWICK: General Practitioner. Population 600. Office facilities available. Former physician left practice of twelve years to retire to West Coast. Five minutes from country club and twenty minutes from Mississippi River. Contact: Le Roy Foltz, 329 Marion, Chadwick 61014, 815-684-5128. (4)

CHAMPAIGN-URBANA: Opportunities for Neurologist, Nephrologist, Internists, and Orthopaedist in prospering 30-man group. One-third of doctors under 35. Affluent Big-10 town of 90,000 with top schools and real cultural/recreational attributes. Full Associateship after 18 months on excellent guarantee. Write or call collect: Joseph A. Zalar, Jr., M.D., Christie Clinic, Champaign, 61820, 217-384-1240. (4)

COAL CITY: General Practitioner. Growing community with trade area of 15,000, offers to a physician a completely equipped office. Free for six months. Only one hour from Chicago, three hospitals nearby, and great recreational facilities for leisure. Contact: John Nicoletti, Coal City, 60416, 815-643-8608. (4)

DE KALB: 33,000 Population. University town. Good schools—all religious denominations. Complete office facilities—X-ray & Lab. with 6 physicians—including OB-GYN, General Surgeon, Family Practitioners. Need Internist & Family Practitioner. Financial assistance available. Contact Gordon Graham, 901 N. First, De Kalb, 60115, 815-756-6611. (4)

EFFINGHAM: Service area 60,000—Central Illinois at intersection of I-57 and I-70. G.Ps., OB-GYN, Urology, Orthopedic Surgeon, Internal Medicine, Clinic or solo practice. Progressive community. Contact: Don Kabbes, 503 North Maple Street, Effingham, 62401, 217-342-2121. (4)

EVANSVILLE: General Practitioner. Population 1,000 with a large rural area. We are 15 minutes away from any one of three new hospitals. We stand ready to build to one or two doctors' needs. Also, we have financial assistance available. Contact: Jim Biethman, Box 144, Evansville, 62242, 618-853-2629. (4)

FAIRFIELD: General Practitioners Wanted. Are you bored and want a challenge? Do you want to practice where they don't ask about your diploma, or your specialty? Are you genuinely interested in people and their problems, rather than diseases and cases? If so, come on down to Fairfield and get your feet wet! Write or phone collect: Jerry Vaughan, Box H, Fairfield, Illinois 62837, 618-842-2167. (4)

FLORA: Population 6,000. G.P., Int., OB-GYN, Ortho. Surg., Anesth., Ophth., ENT. Group or Solo Practice.

Nine physicians at present. One hundred miles east of St. Louis on Route 50. Financial assistance available. Excellent School system. Outstanding parks and recreational facilities. Visit at our expense. For an appointment contact: Alvin J. Uebinger, Administrator, Clay County Hospital, P.O. Box 280, Flora, 62839, 618-662-2131. (4)

FREEPORT—population 30,000. Internist & Pediatrician urgently needed to join a corporate 9 man multispecialty group. Established in 1948, new building in 1970. Salary first year. Fringe benefits include $50,000 life policy and retirement plan. For additional information—Freeport Medical Clinic, LTD., Freeport, 61032, K. H. Shons, Business Manager, 815-233-6131. (9)

GALESBURG: Galesburg Clinic; population 40,000. Twelve man multispecialty group seeking Ophthalmologist, Orthopedist, Internists, Urologist and Family Practice. New clinic building connected to new hospital. Home of Knox College. Excellent schools, recreational and transportation facilities. A fine opportunity. Contact: L. S. Doyle, Administrator, 320 North Kellogg St., Galesburg, 61401, 309-342-1161. (4)

GENESEO: Ped., OB-GYN, F.P., Orth. Surg., Int. Med. Population 7,000 serving area 30,000 on Interstate 80, 2½ hours from Chicago, 25 miles from Quad-Cities metropolitan area over 300,000. Safe, ideal, small city living, 110 bed ultra modern hospital, excellent schools, recreational facilities. Clement G. McNamara, 210 W. Elk St., Geneseo. Call Collect 309-944-6431. (4)

GIBSON CITY: Int., Ped., OB-GYN, G.P. Rural community with hospital facilities. Half-hour to Champaign-Urbana or Bloomington-Normal or two hours to Chicago loop. Office facilities are available as well as financial assistance if necessary. Contact: Robert E. Jones, Gibson Community Hospital, Gibson City, 60936, 217-784-4251. (4)

HARVARD: General Practitioner. Population, 5250 with trading area 18,000. Only three physicians. Seventy miles from Chicago, 30 miles from Rockford, 75 miles from Madison and Milwaukee and 8 miles from Lake Geneva-Lake Delavan resort area. Sound economic and growing area. Contact: Mrs. Catherine K. Oost, 58 N. Ayer St., Harvard 60033, 815-943-5261. (4)

HERRIN: Int., G.P., ENT, Anthes. Population 10,000-trade area 40,000. Near S.I.U., 90 miles to St. Louis. New offices, modern hospital. Beautiful vacationland, all outdoor sports. Financial assistance and salary guaranteed. Call collect Larry Feil 618-942-4710, Herrin Hospital, Herrin, 62948. (9)

ILLINOIS DRUG ABUSE PROGRAM: Full or part-time work in general medicine, psychiatry, research, administration, or any combination of the above. Excellent opportunities for treating all types of chemical dependence, as well as carrying out research on medical and psychiatric aspects of the addiction problem. Also, full or part-time work in special units including alcoholism, severe medical and psychiatric problems, and a discreet operation serving pregnant addicts. Contact: Edward C. Senay, M.D., 5700 Lake Shore Drive, Chicago, 60637, 312-955-9800. (4)

LEROY: Population 2500. Opening due to death of only physician. Large practice. Excellent Clinical and Office facilities. Financial assistance available. For Complete Information, Contact: Al Provasi, 307 N. Chestnut St., LeRoy, 61752, Phone: Res. 309-062-5101; Bus. 309-962-2721 or Craig Pillatsch, 101 W. Center Ct., LeRoy, 61752, Res. 309-962-7781; Bus. 309-962-7171. (5)

LIBERTYVILLE: Family Physician wanted for medical group of three Family Practitioners. Originated in 1952—Incorporated in 1964—Remodeled in 1972. Fringe benefits: hospitalization, pension, profit sharing, bonus and others. Complete office facilities. Please Contact: Mark H. Fields, Jr., M.D., 716 S. Milwaukee Avenue, Libertyville, 312-362-1390. (4)

LITCHFIELD: G.P., OB-GYN, Ped., Int. Population 7300, Trade Area 50,000 in 15 mile Radius. New 134 bed hospital. Midway between Springfield and St. Louis, Mo. on I-55. Good schools. Good recreational facilities. Financial assistance can be arranged. Contact: John Short 723 N. Van Buren, Litchfield, 62056, 217-324-3937. (4)

MACOMB: G.P., Int., Ped. Population 19,000. Home of Western Illinois University. 200 bed open staff hospital. Modern offices available for solo or clinic practice in all specialties. Guarantee plus fringes. No pollution, crime or traffic problems. Rural living with urban culture and recreation. Contact: D. H. Dexter, M.D., Macomb Clinic, Doctors Lane, Macomb, 61455, 309-833-4176. (4)

MARSHALL: General Practitioner. A new medical center now open located 17 miles from Terre Haute where hospital is available. Recreational services include fishing and camping. Another lake is under construction for boating and swimming. Excellent schools. Financial assistance available. Contact: Donald B. Smitley, Cork Medical Center, 410 N. 2nd St., Marshall, 62441, 217-826-2361. (4)

MAYWOOD-DIXON: Population 35,000 and 20,000 respectively. Expanding multispecialty groups, directed towards comprehensive medical care—excellent opportunities for Internist, General Surgeons, Pediatricians, Emergency Room Physicians—now and in the future. Contact: Gene M. Gaertner, M.D., 1908 St. Charles Rd., Maywood 60153, 312-344-5300. (4)

METROPOLIS: Physicians wanted. G.P., OB-GYN. Complete office facilities. Financial assistance available. Modern, well equipped hospital serving tri-county area in scenic southern Illinois. Contact: Charles Russell, Administrator, Massac Memorial Hospital, Metropolis, 62960, 618-524-2176. (4)

MOMENCE: General Practitioner. Population over 4,000. Opening new health center 14 mi. from Kankakee and 50 mi. from Chicago on Route 1. Office facilities available—some financial assistance available. Contact Rachel Simpson, 210 N. Dixie, Momence, 815-472-2751; or George Duguay, N. Dixie Hwy., Momence, 815-472-4833. (4)

MONMOUTH: Service area population: 30,000. Opening for General Practice and General Surgeon with training in Orthopedics and/or Vascular Surgery. Modern well-equipped hospital—141 beds. Near Highways I-74 & I-80. Daily rail to Chicago. Flight service available. Safe place to raise family. Near Medical School. Liberal Arts College. Contact: Roger E. Gurholt, 1000 W Harlem Ave., Monmouth, 61462, 309-734-3141 X 261. (4)

MONTICELLO, IOWA. Trade area 15,000. Need six or seven additional doctors. Presently served by four physicians, all involved in General or Family practice. Could afford some specialties in combination with General Practice. Financial assistance available. Contact John Wild, c/o John McDonald Hospital, Monticello, Iowa, 319-465-3511. (4)

MT. CARMEL: General Practitioner. Population 8,100.

Medical service center for 25,000 population. Complete medical facilities. Five doctors at present. Rapidly growing area. All recreational and cultural facilities nearby. Assistance available. Contact: Walter Curry, 20 Lambert Drive, Mt. Carmel, 62863, 618-262-4534. (4)

OLNEY: Weber Medical Clinic, 23 man multispecialty group. Population 100,000+, new building, patient load increased 20%. OB-GYN, Orth., Int., Ophth., Oto., Derm., Urol., 5 weeks vacation, 1 week educational leave per year, pension plan, life insurance, disability. Lovely community, no ecology problems. Contact: David L. Potter, Adm., 1200 N. E. St., Olney, 62450, 618-395-2223. (4)

OTTAWA: Population 20,000. Opening in Internal Medicine at the Ottawa Medical Center, S.C. Eight-man specialty group. Seventy-five minutes from Chicago Loop. New hospital opening date in October, 1973. CONTACT: D. E. Morehead, M.D., 313 W. Madison St., Ottawa, 61350, 815-433-1010. (5)

PAW PAW "Rent Free" Modern Clinic Available: Progressive, growing community, wishes to locate services of general practitioner. Modern medical, dental clinic provided. Maintenance of brick building by occupants only requirement. Excellent opportunity for profitable practice, plus ideal family living in friendly small town atmosphere. Contact: Mrs. Darlene McLaughlin, Paw Paw, 815-627-8441. (5)

PEORIA: Population 325,000. Emergency Room position for fulltime physician. Located midway between Chicago, St. Louis, and Iowa City. Excellent minimum salary and benefits. 824 bed community general teaching hospital. Affiliated with University of Illinois Medical School. Illinois State Regional Trauma Center. Contact: Personnel Director, St. Francis Hospital, Peoria, 61603, 309-672-2304 (4)

PINCKNEYVILLE: Population 3500. Opening in small Group-Partnership for Family Physician. Fully accredited hospital. Complete office facilities. No financial investment. Excellent compensation and working conditions. Sixty miles from St. Louis. Good recreational facilities. Contact: Clarence E. Cawvey, M.D., 206 No. Main St. Pinckneyville, 62274, 618-357-2131. (4)

PONTIAC: Population 11,000. 100 miles south of Chicago on Route 66. 10 physicians. Several retiring. Wanted: Family Practitioners, General Surgeon (one on staff), Internal Medicine (none on staff). Paid Emergency Room coverage available. Financing and office space available. Contact: Dale Budde, 610 East Water St., Pontiac, 61764. Call collect: 815-844-5134. (4)

PRINCETON: Population 7,800; County population 38,000. Excellent living conditions; good family community—no problems. Modern 180-bed hospital. Unlimited income for Family Physicians and Pediatricians. 2 hours—Chicago; 1 hour—Peoria & Quad Cities on I-80. Call collect: John Revell, 606 South Main St., Princeton, 61356, 815-872-1255 or 815-875-3292. (4)

PROPHETSTOWN: Small town boy?? If you are a physician interested in General Practice, and want a small town life for your family, then Prophetstown, Illinois may be the place for you. We invite your inquiries. Contact Calvin W. Schuneman, 343 Washington Street, Prophetstown, 61277, 815-537-2301. (4)

QUINCY: OBG, Ped., Ortho., Fam. Prac., Derm., GU, Ind. Med. to join 17-man established clinic. Large modern clinic, many benefits, two well-equipped hospitals. Excellent schools, cultural, recreational advantages. Good family city. Above average earnings. Write or call collect: Mr. Judson C. Green, Quincy Clinic, 1400 Main St., Quincy, 217-222-6550. (4)

RANSOM: General Practice Opening. Death compels sale of practice. Modern equipment and brick building—consists of Doctor's nurses and receptionist's offices, large reception room, laboratory and office-treatment rooms. 80 miles southwest of Chicago. St. Mary's Hospital staff in Streator, practice reaches a 50 mile radius. Contact: Mrs. D. Jones, Ranson, 60470, 815-586-4229. (4)

ROANOKE: General Practitioner. Population 2,050. Opening for one or two physicians. Excellent location for clinic type facility. Financial assistance available. Space available, or will build to suit. Twenty-five miles from Peoria and Bloomington. All recreational facilities nearby. Contact: Elton Ulrich, Savings Building, Roanoke, 61561, 309-923-2831. (4)

ROSICLARE: G.P., Ped. Hospital serves 2 counties-approximately 10,000 people. Three Physicians at present. Office Facilities, financial assistance & housing available. Modern, well equipped hospital. Located on Ohio River and in recreational area. Contact: Loeta Allen, Hardin Co. General Hospital, Rosiclare, 62982. Call collect: 618-285-6634. (4)

SALEM: G.P., Ped. Growing community with large rural area to serve. Financial assistance available. Fine schools and other municipal services. New 60 bed hospital addition under construction. Eighty miles from St. Louis. Contact: Edris Bachman, 520 Markland, Salem, 62881, 618-548-1944. (4)

SANDWICH: Population 5,500. 92-bed hospital serving 30,000. Need for two or three General Practice Physicians plus Internist plus Obstetrician plus Pediatrician. Single or group practice opportunities. The good life is here including economics) and also an hour from the Loop, etc. Contact: Marvin Tice, 11 East Pleasant Avenue, Sandwich, 60548, 815-786-8484. (4)

SAVANNA: G.P., Int. 5,000 population on Mississippi River, 40 bed open staff hospital. Exceptional recreational facilities, Exeellent schools, Churches of all denominations. Option to practice alone or in partnership. Financial assistance available. Contact: Wm. Dayton, 202 Meadow View Knoll, Savanna 61074, 815-273-2221. (4)

SENECA: Wanted Family Physician—population 2,500, 70 miles southwest of Chicago. No Doctor in town. Beautiful office building and equipment. Offer free rent with option to buy. Guarantee monthly gross. General Surgery knowledge helpful but not necessary. Two new hospitals—12 miles away with country driving. Contact: Marion L. Osborne, 135 E. Lincoln St., Seneca, 61360, 815-357-6172. (4)

SHERIDAN: General Practitioner. One or two doctors for modern medical center. Financial assistance available including part-time staff physician for State institution. Excellent hospital facilities. Good opportunity for doctor who enjoys his family. Contact: John Yuhas, Sheridan, 815-496-2272 days or Alvin Sebby, Sheridan, 815-496-2620 evenings or weekends. (4)

SOUTHWESTERN TERRITORY: General Practitioner, Towns of Brighton, Medora, Piasa, Shipman, combined area population 7500. Office and facilities available, Partnership and or financial assistance available. Five general hospitals in surrounding area, country living, excellent churches, schools, shopping areas, St. Louis and Springfield one hour away. Contact: Kenny Lahr, Piasa, 62079, 618-729-4142. (4)

STREATOR: Population 18,000. Multispecialty group, 7 physicians at present. New air-conditioned facility across from St. Mary's Hospital. Guaranteed minimum salary. Incorporated. Paid vacation and post-graduate study. Excellent insurance benefits. All specialties needed urgently. Contact: Dr. C. T. Hawkins, Streator Medical Clinic, S. C., 104 Sixth Street, Streator, 60364, 815-672-0511 (4)

STRONGHURST: Progressive small town serving large rural area. Close to large advanced medical facilities, recreational facilities nearby. No racial or environmental problems. Contact: Robert Dillon, Stronghurst, 61480, 309-924-6411. (4)

TAYLORVILLE: Population 12,000. Two-year old, seven physician multispecialty clinic seeking General Practitioners, Internists and OB-GYN. Salary first year. Full partnership thereafter. 25 miles to Springfield and SIU Medical School. 90 miles to St. Louis. Many recreational facilities nearby. Contact: Tom Brewer, 600 N. Main Street, Taylorville, 62568, 217-824-8191. (4)

WATSEKA: Population 5,800. Opening in established medical clinic. 4 Physicians at present. Complete office facilities. Lab & X-Ray. Need GP and Internal Medicine. Contact: Francis Carter, 845 S. 4th Street, Watseka, 60970, 815-432-2461. (4)

WITT: Physicians needed in section of county to serve over 20,000 people. A modern building complete and ready for two doctors. Financial assistance available. Country living with access to big city attractions, St. Louis, Mo. Contact: Louis Schwartz, Witt, 62094, 217-594-2431. (4)

WOODSTOCK: Int., Ped. to join young 9 man multispecialty group in rapidly expanding area 60 miles NW. of Chicago—Excellent Hospital—1st year minimum ($30,000)—Full member after one year—No buy-in's. Contact: Dr. Pensinger, Kishwaukee Valley Medical Group, S.C., 13707 W. Jackson St., Woodstock, 60098, 815-338-6600. (4)

Bladder Cancer

The ideal treatment for bladder cancer is often difficult to decide. The disease may be part of a widespread disorder of the urinary tract and multifocal in origin, with growths spread over a considerable time and widely disseminated. Moreover, until the cancer is advanced there is no sure way of predicting its future growth or the neoplastic potential of the urothelium in general. The natural history of the disease suggests that a mechanism operates which for long periods may effectively control its progress. Preliminary evidence suggests that the mechanism may in part be immunological. (Immunological Characteristics of Bladder Cancer, *British Medical Journal*. Vol. 4, December 2, 1972, pgs. 502-503.)

★

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Use of Patient's Own Blood Can Avoid Risk of Hepatitis

The risk of infectious hepatitis could be avoided by using the patient's own blood for transfusions, Dr. Matthew M. Block said at the annual scientific assembly of the Florida Academy of Family Physicians, recently held in St. Petersburg.

The procedure was safe and successful for adults not suffering from a debilitating disease that suppresses red cell production, said Dr. Block, professor of medicine and chief of the hematology service at the University of Colorado Medical Center, Denver.

The procedure entails taking a pint of blood from the patient at 3-or-4-day intervals, starting 21 days before a scheduled operation—the 21-day period being dictated by the length of time blood remains fresh under refrigeration.

Each time blood is taken, the patient is given 5 cc Imferon intravenously to replace approximately the same amount of iron in the withdrawn blood. The iron thus given regenerates hemoglobin so rapidly the patient's blood count and fluid total (10½ pints) remain stable, he said.

By the time of the operation, the hospital has 6 pints of the patient's own blood—the most that is likely to be needed to compensate for normal bleeding.

The procedure was attempted after experiments with five prisoner-volunteers at the state penitentiary.

Each prisoner gave 1 pint of blood five times a week for 23 weeks. Because of the iron injections, none of the five suffered ill effects from the massive blood-letting

In about 3,200 injections of iron subsequent to the prison experiment, there were few allergic reactions. The only severe reaction observed was in a patient with rheumatoid arthritis.

On the average each patient received 4 injections of 10 cc each, and a few had as many as 200 injections over a year. Of the 440 patients who were the subject of detailed follow-up, only 1 experienced a drop in blood pressure.

In these instances, auto-transfusion avoided the danger of hepatitis transmission, Dr. Block said.

Commercial blood banks that buy blood from walk-in donors are especially prone to receive contaminated blood from derelicts, alchoholics, and dope addicts, he warned.

Community blood banks have a rate of overt infectious hepatitis of 1 per 200 transfusions, and of 7 occult cases of hepatitis per 100 transfusions.

Another advantage of auto-transfusion is that it eliminates costly, time-consuming cross-matching, thereby reducing the cost of a pint of blood by $10-15, Dr. Block said.

Several hospitals are preparing to adopt auto-transfusion: These include Fitzsimmons Army Hospital in Denver; St. Luke's Hospital in Milwaukee, where open-heart surgery is frequently performed; the Latter Day Saints Hospital in Provo, Utah, and the Loveless Clinic in Albuquerque, N.M.

There are objections to the procedure.

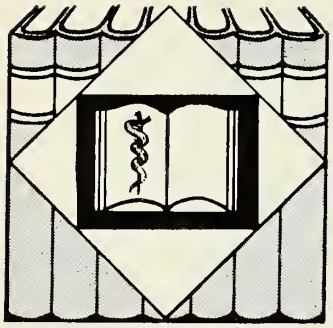
Hospital residents are sometimes frustrated in looking for sterile bottles and a safe place for storage; getting blood from banks requires only a telephone call.

Another source of resistance is the patient who is not willing to pay the hospital's nominal service charge for withdrawing and storing blood because his medical insurance does not cover such cost, but does pay for transfusions.

The Food and Drug Administration has authorized the nonexperimental use of Imferon in 2-cc intravenous injections, the physician said.

Noting that the Imferon label specifies intramuscular use, Dr. Block said that method is too painful and he administers it intravenously. He noted that oral ingestion is impractical because the body cannot absorb enough to compensate for the iron lost in blood removed for auto-transfusion. ◄

(*Internal Medicine News*, Oct. 1, 1972.)



the doctors library

The Care of Minor Hand Injuries, (Third Edition) Adrian E. Flatt, C. V. Mosby Co., St. Louis, Mo., 1972

This revised third edition of a previously well received book numbers 293 pages. The first part deals with general principles of care and the second portion concerns the care of specific injuries. In the section of general principles are chapters on functional anatomy, principles of care, surgical techniques as applied to hand injuries and a classification and method of examining injuries. The first two areas are dealt with succinctly and lucidly. The latter two are somewhat more detailed, but for anyone treating hand injuries they contain a wealth of information which can be utilized again and again. The second portion of the book discusses specific injuries which run the gamut from injuries of the skin and nails to tendon injuries, joint injuries, and fractures. Each and every one is well handled. They do not bog down in endless discussions of numerous alternatives in treatment. Especially good are the chapters on finger tip injuries, fractures and infections.

The profuse use of illustrations enhances the value of this volume immeasurably. All of the necessary points are well illustrated and in a detail which is simple yet gets home the salient points. At the end of the book are references for each chapter which the more searching student may wish to peruse.

This reviewer recommends this book to anyone treating acute hand injuries. This book should be available in emergency rooms rather than sitting in a reference library. It is not a scholarly, researched tome on hand injuries but, rather it is a practical book on the management of acute hand injuries. There is a complete and clear index. One could, at a moments notice, be presented with a hand injury and find a highly practical method of dealing with it. When reading the book it is obvious that the author has treated personally all of the injuries with which this volume is concerned and this arbeit represents a distillate of considerable experience. ◄

Norman E. Hugo M.D.

New Way To Control Obesity

Two Brooklyn VA doctors have found a spot in your brain that can keep you from getting fat.

Dr. Albert F. Debons and Dr. Isidore Krimsky, of the Brooklyn, N.Y., VA hospital staff, have figured how the brain's data processing center (that regulates appetite) operates to keep average people from over-eating.

The two scientists expect the finding to be applied, eventually, to prevent people from eating so much that they become obese, perhaps by developing a pill that will regulate this spot in the brain.

Writing in the May 1972 issue of the journal *Postgraduate Medicine,* the two doctors presented "evidence that the satiety center participates in the mechanism for maintenance of a normal caloric balance by serving as a site where information on the status of glucose utilization is monitored and transmitted into the central nervous system."

BLUE SHIELD REPORT FOR *Illinois Physicians*

Blue Cross Adopts New Symbol; Will Implement 10-Point Program

The Blue Cross symbol, known throughout America if not the world, has undergone a change in design. The new symbol, illustrated below, features a stylized human figure in the center of the traditional blue cross. The figure replaces a seal which contained various emblems associated with health care and emphasizes Blue Cross' expanding role of service to people.



New Blue Cross symbol replaces 34-year old seal that featured medical emblems in center of cross.

The change to the new emblem was announced by Chief Executive Officer Robert M. Redinger of Blue Cross-Blue Shield. "The human figure", he said, "is our new symbol that replaces the American Hospital Association seal we have used up to now, and shows that the primary concern of the Blue Cross system is to serve the public. It is meant to emphasize our service to people and our expanding commitment to today's consumer.

"The Blue Cross organization has come a long way since it covered only hospital expenses", he emphasized. "In fact, today, we are paying more claims for out-of-hospital services than for in-hospital expenses. As many as three out of ten medical procedures could probably be performed as effectively, and certainly more economically, outside the hospital or on an outpatient basis".

Adoption of the new symbol, Mr. Redinger explained, will be in keeping with other elements of a new 10-point program that call for increasing consumer representation on Blue Cross governing boards, the growing use of consumer advisory committees, and a stepped up campaign to increase consumer knowledge, not only in health care, but also of costs.

Blue Cross programs will also encourage hospitals and other health care providers to accept payments negotiated and agreed on in advance; support area-wide planning to control and legally prevent building of unnecessary facilities; share use of computers and other technology to assist health care providers and other community health agencies; support improved review of hospital utilization and control standards of Blue Cross performance.

Spring Series of Workshops Scheduled

The Spring series of daytime workshops for medical assistants in central and downstate counties of Illinois has been scheduled by the Professional Relations Department of the Illinois Blue Shield Plan. Letters to physicians in the counties announced the dates and locations and asked for their assistance in providing the names of office assistants who would attend. A total of 20 workshop meetings have been scheduled, the first on April 4 in Mt. Vernon. Others will follow through June.

Workshops in 1973 will be conducted from 10:00 AM to 12:00 Noon, followed by a luncheon. The program will be repeated in the afternoon from 1:30 PM to 3:30 for those unable to attend the morning session. Medical assistants need only to attend one session, morning or afternoon to be guests at the luncheon.

The format of the meetings has been altered somewhat this year to provide maximum time for discussions and questions. Members of our Professional Relations Department will conduct the meetings and give special attention to the newly-employed assistants. Discussions and instructional materials will concentrate on Blue Shield benefits, new Indemnity certificates and ways to file Physician's Service Report forms to prevent delays in payment. Additional meetings are as follows:

Wednesday, April 4	Ramada Inn	Mt. Vernon
Thursday, April 5	Ramada Inn	Marion
Wednesday, April 11	Hyatt House	Belleville
Thursday, April 12	Holiday Inn	Edwardsville
Wednesday, April 25	The Gardens	Litchfield
Thursday, April 26	Ramada Inn	Effingham
Wednesday, May 2	Ambassador Hotel	Decatur
Thursday, May 3	U.S. Grant Motor Lodge	Mattoon
Wednesday, May 9	Ramada Inn	Quincy
Thursday, May 10	Sheraton Inn	Springfield
Wednesday, May 16	Ramada Inn	Champaign
Thursday, May 17	Palamar Inn	Pontiac
Wednesday, May 23	Ramada Inn	Peoria
Thursday, May 24	Holiday Inn	Bloomington
Wednesday, May 30	Sheraton Inn	Rock Island
Thursday, May 31	Sheraton Inn	Galesburg
Wednesday, June 6	Ramada Inn	Ottawa
Thursday, June 7	Ramada Inn	Kankakee
Wednesday, June 13	Henrici's Motor Inn	Rockford
Thursday, June 14	Ramada Inn	Dixon

(This report is a service to the physicians of Illinois)

ASK BLUE SHIELD . . . ABOUT MEDICARE

Complete Information Necessary On Medicare Claims

Illinois Medical Service, Part B Medicare carrier for physicians in Cook County, processed over 920,000 SSA 1490 Request for Medicare Payment claims in 1972 with payments of approximately $45,900,000. In 1973 over a million claims are expected to be received and payments made of over $61,000,000, a year-end projection indicates. Payments in nearly 10 percent of claims received are delayed because information required on the claim form is incomplete.

Every item of information omitted from the SSA 1490 form delays the claim; and the omission of a single item can delay the claim for days. Other omissions can extend the delay of payments for months.

Claims examiners attempt to obtain as much missing information as possible by contacting the physician by phone. When letters must be written delays are extended. Incomplete information leads to higher administrative costs, both for the Part B carrier and for the physician who must review his records for the information needed.

The three items most often missing from a Medicare claim are:

(1) The diagnosis
(2) Itemization of all charges, and
(3) Itemization of specific charges.

The diagnosis is essential for the Part B carrier to relate the services provided to the treatment of the illness or injury. It must be included on the physician's statement to the patient when billing the patient directly. This eliminates the need for contacting the physician for the diagnosis when the patient files for benefits and neglects to complete line 4 of the SSA 1490.

Itemization of all charges means listing the date of each service, place of service, description of each service, whether surgical or medical, nature of illness or injury, and charge for each service on the SSA 1490 or statement to the patient. For example, a bill for several office visits plus in-hospital medical care should list the date and charge for each office visit plus the dates and charge for the in-hospital care.

Itemization of specific charges means to list the charges for each specific service included in an overall charge. For example, a charge for an office visit during which a complete blood count and an X-ray were taken should include the specific fee for the complete blood count and for the X-ray plus the charge for the office visit. Similarly, a charge for in-hospital visits should show the number of days the patient was visited and the charge for each day. If the fee for the initial visit exceeds that of subsequent visits, the difference in the amount charged must be shown.

Below is listed the specific information which is required on all claims for Medicare benefits. On Part I of the 1490:

(1) Give complete name of patient as listed on patient's Health Insurance Card.
(2) Every claim submitted must include the patient's complete Health Insurance Claim Number, and the letter suffix, as it appears on the patient's Health Insurance Card. Adjacent to the letter suffix are boxes to indicate whether the patient is a male or female. Because names are confusing either box should be completed. This helps us to know, for example, whether Connie R. Carson or Marion N. Jacobs is male or female.
(3) Patient's address and telephone number. This helps to establish the correct identity of the patient.
(4) Diagnosis and description of illness or injury.
(5) Name of supplementary insurance company and address; policy number; or Public Aid number.
(6) Signature of the patient.

Completion of Part II of the SSA 1490 Request for Medicare Payment form will be discussed in the April issue of "Ask Blue Shield About Medicare."

Precautionary Notice to Physicians Accepting Assignment On Part B Medicare Claims

Physicians accepting Part B Medicare assignments should be aware that revisions to Medicare regulations in November 1972 provided issuance of a precautionary notice legend on beneficiary checks. Because there will be a considerable delay in the issuance of checks carrying these legends, this reminder is being brought to the attention of physicians.

The notice states: "As provided by the terms of the law under which this check is issued, the undersigned payee, in accepting assignment, agreed that the charge determination by the Medicare carrier shall be the full charge for any service for which the check is payable. The patient is responsible only for the applicable deductible and coinsurance, and for non-covered services."

This precautionary notice is in addition to the penalty clause notice saying: "This payment is made with Federal funds. Fraud in procuring, forging of signature or endorsement or materially altering this check is punishable under the U.S. Criminal Code."

Lab Closings End Medicare Participation

The laboratories listed below ceased operations and were notified by the Social Security Administration that payments for Medicare services under the Health Insurance program would no longer be made after the following dates:

November 18, 1972 for
Gerber X-Ray and Clinical Laboratory
2400 West Devon Avenue
Chicago, Illinois 60645

January 1, 1973 for
Clybourn Medical Laboratory
1322 North Clybourn
Chicago, Illinois 60610

(This report is a service to the physicians of Illinois)

IMJ

Illinois Medical Journal

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(Cover by Alicia Albanese Kolton)

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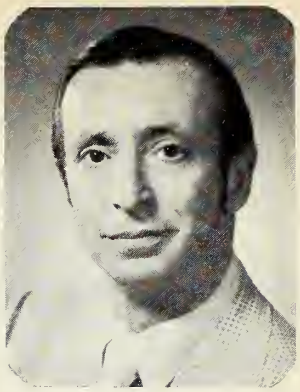
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The President's Page

A Good Swift Kick...

"I believe the consumer should have a strong voice . . . if not the sole voice . . . in area-wide planning agencies as well as hospitals."

Herbert S. Denenberg
Interview with "The Review," 1972

"What has to be done, has to be done by government and people together or it will not be done at all."

President Richard M. Nixon
Inaugural Address, January, 1969

"To be effective and efficient, public health programs should be local. The state should be a catalyst, assisting these municipalities and counties to set up cooperative, workable programs."

Daniel Walker
Position Paper on Health Care, 1972

Will this idealism ever become a reality? Will the "consumerism" approach alleviate the problems that now plague our health care delivery system? At present, the outlook is doubtful.

Why? Consumers . . . physicians . . . medical organizations . . . government . . . media are all failing each other in their own individual way.

Here's what I mean:

On November 16, 1972 the President's Committee on Health Education reported, "Of $75 billion spent last year in the health area, about 92% was spent after the illness occurred. Less than 1% was spent for health education, 2% for preventive medicine and 4.5% for biomedical research."

I believe it's time for us all to step back, survey the health situation of this country and start again. This time with each person carrying his fair share.

The National Health Council recently stated: "There is evidence that the next major advances in the health of our citizens will come through health education and preventive medicine—not necessarily through more doctors and high costs."

If we can improve the "personal health practices" of the people, it would raise the level of the nation's health more than anything the medical profession could do alone.

Why has the appeal for better health practices by the public grown with such a wave of interest? In this country today, 75% of all deaths are caused by cardiovascular disease, cancer and accidents. Middle income families spend $2,500 a year or more on food, yet 37% of them are poorly nourished. And 70% of the people refuse to use their seat belts.

In all these cases, the public could be doing a great deal to protect itself . . . but it refuses. Instead it proposes the enactment of some form of comprehensive national health insurance to provide MORE medical care to MORE people at a reduced cost. Attacking the problem in this manner is like shutting the door AFTER the flies are in the house.

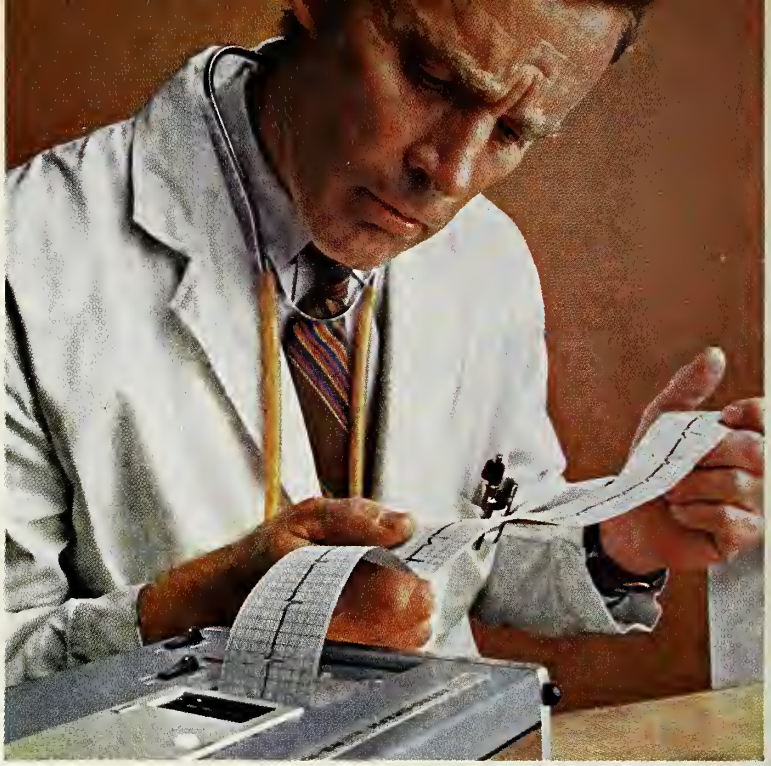
What we need is a vigorous emphasis on the neglected area of health care and preventive medicine with efforts to AVOID the illnesses and suffering.

The majority of Americans equate preventive medicine with TREATMENT. We want to do something AFTER a disease or accident strikes . . . Even though it is proven that many of these illnesses need NOT occur and that changes in an individual's habits could work to prevent them.

As one writer put it, "the greatest potential of improving the health care of the American

(Continued on page 278)

When cardiac complaints occur in the absence of organic findings, underlying anxiety may be one factor



The influence of anxiety on heart function

Excessive anxiety is one of a combination of factors that may trigger a series of maladaptive functional reactions which can generate further anxiety. Often involved in this vicious circle are some cardiac arrhythmias, paroxysmal supraventricular tachycardia and premature systoles. When these symptoms resemble those associated with actual organic disease, the overanxious patient needs reassurance that they have no

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions

Abstracts of Board Actions Board of Trustees Meeting

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. It covers only major actions and is not intended as a detailed report. Full minutes of the meetings are available upon any member's request to the headquarters office of the ISMS.

January 20-21,1973 **Chicago**

1973 Operating Budget Approved

The Board of Trustees approved an operating budget of $1,028,325 for 1973, up $92,925 over the 1972 revised budget. The budget reflects the $25 dues increase voted by the House of Delegates last year. The society has operated on a deficit budget for the past two years. A plan to conserve funds over the next five years, to avoid a further increase in dues during the period, was also adopted.

Ask Members to Protest TV Programming

"Action Report" will urge ISMS members to write Eaton Industries in protest of its sponsorship of "What Price Health?" a recently aired TV program which the Board denounced as misleading, slanted and unfair to the medical profession. It was suggested during an open forum, in which officers of Chicago Medical Society branches participated, that ISMS should develop an "offensive team" to think ahead to possible criticism and a "defensive team" to act on short notice when the medical profession is given a "black eye".

Conference on Migrant Health Care

ISMS will co-sponsor a U.S. Department of Health, Education and Welfare Conference on Migrant Health Care, February 19-20, Chicago. No ISMS expense is involved.

Peer Review

The Board requested the Council on Economics and Peer Review to review the existing peer review guidelines, calling upon the Committee on Constitution and Bylaws as needed, and report back to the Board regarding areas of possible clarification.

At the request of the Council on Economics and Peer Review, the Board referred the question of experimental medical practice to the ISMS Policy Committee for development of policy which formally reaffirms the AMA Judicial Council's interpretation of medical experimentation in relation to the Principles of Medical Ethics. A recommendation concerning the amount local peer review committees should charge insurance companies for reviewing cases was referred back to the council for further study.

Because fee adjudication by peer review committees is difficult without access to actual charges, the Council on Economics and Peer Review has developed a resolution asking the House of Delegates for authorization to request all insurance carriers to furnish state and component peer review committees with such data. Component peer review committees encountering an uncooperative carrier would be asked to inform the ISMS Board of Trustees which would take appropriate action. The resolution was endorsed by the Board.

The Board refused endorsement of a proposed resolution calling for a fee survey and the use of a Relative Value Scale in conjunction with the application of usual, customary and reasonable fee payments.

Federal Tax on Journal

The Internal Revenue Service, which originally assessed the Illinois Medical Journal more than $30,500 for unrelated business income in 1968 and 1969, has offered to settle the one case for about $2,500. The Board agreed to pay this amount under protest, with the provision that if it later appears feasible, ISMS will sue to recover the amount paid.

Substitution of Drugs by Pharmacists

The ISMS Executive Committee will meet with officials of the Illinois Pharmaceutical Association to seek ways to permit pharmacists to substitute prescribed drugs under certain conditions. ISMS policy supports present state law which makes such substitution unlawful without physician approval. While the Council on Governmental Affairs supports the official ISMS position, the pharmaceutical association maintains the restriction is too inflexible and should be modified.

ISMS Eligible for Additional Delegate to AMA

Due to a growth in membership, the AMA delegation from Illinois will increase from 11 to 12 members, effective with the annual meeting of the American Medical Association in June. A plan to annually name the ISMS president and president-elect to this spot (delegate and alternate, respectively) during their terms of office, was presented. (The Chairman of the Board would substitute if the president or president-elect are already members of the AMA delegation.) The Board's recommendation to the House of Delegates on this matter will be made in March.

To better coordinate the society's program with the responsibilities of the AMA delegation, the delegation will meet with the ISMS Executive Committee prior to the AMA June meeting.

Public Aid Billing

The Board acted to approve a proposed simplified Illinois Department of Public Aid billing form. The IDPA was stimulated to act as a result of prodding from ISMS President-elect Dr. Willard Scrivner.

The Board endorsed the findings of the Committee on Governmental Health Programs Reimbursement which has reviewed the IDPA practices and agreed that usual, customary and reasonable fees are being set arbitrarily by the department. Action was initiated at the request of the Illinois Academy of Family Physicians. The Board will request that IDPA henceforth allow ISMS and its component societies to have a voice in determining the basic principles on which such fees are established.

At the request of the Council on Mental Health and Addiction, the Board directed the Council on Economics and Peer Review to investigate the justification for the $300 per year maximum allowable for outpatient psychiatric services to Medicaid recipients. Also at the request of the council, the Board reaffirmed its position that physicians should be permitted to bill IDPA for services provided under their direction and/or supervision as well as those provided directly by the physician.

In a related action, the Board endorsed the use of relative value to measure units of time spent by psychiatrists if payment is made on the basis of usual, customary and reasonable fees. The plan has been agreed to between the psychiatrists and the Illinois Departments of Mental Health and Public Aid.

(Continued on page 297)

Pre-Sate® (chlorphentermine hydrochloride)
Caution: Federal law prohibits dispensing without prescription.
Indications. Pre-Sate (chlorphentermine hydrochloride) is indicated in exogenous obesity, as a short term (*i.e.*, several weeks) adjunct in a regimen of weight reduction based upon caloric restriction.
Contraindications. Glaucoma, hyperthyroidism, pheochromocytoma, hypersensitivity to sympathomimetic amines, and agitated states.

Pre-Sate (chlorphentermine hydrochloride) is also contraindicated in patients with a history of drug abuse or symptomatic cardiovascular disease of the following types: advanced arteriosclerosis, severe coronary artery disease, moderate to severe hypertension, or cardiac conduction abnormalities with danger of arrhythmias.

The drug is also contraindicated during or within 14 days following administration of monamine oxidase inhibitors, since hypertensive crises may result.
Warnings. When weight loss is unsatisfactory the recommended dosage should not be increased in an attempt to obtain increased anorexigenic effect; discontinue the drug. Tolerance to the anorectic effect may develop.

Drowsiness or stimulation may occur and may impair ability to engage in potentially hazardous activities such as operating machinery, driving a motor vehicle, or performing tasks requiring precision work or critical judgment. Therefore, such patients should be cautioned accordingly. Caution must be exercised if Pre-Sate (chlorphentermine hydrochloride) is used concomitantly with other central nervous system stimulants.

There have been reports of pulmonary hypertension in patients who received related drugs.

Drug Dependence. Drugs of this type have a potential for abuse. Patients have been known to increase the intake of drugs of this type to many times the dosages recommended.

In long-term controlled studies with high dosages of Pre-Sate, abrupt cessation did not result in symptoms of withdrawal.

Usage in Pregnancy. The safety of Pre-Sate (chlorphentermine hydrochloride) in human pregnancy has not yet been clearly established. The use of anorectic agents by women who are or who may become pregnant, and especially those in the first trimester of pregnancy, requires that the potential benefit be weighed against the possible hazard to mother and child. Use of the drug during lactation is not recommended.

Mammalian reproductive and teratogenic studies with high multiples of the human dose have been negative.

Usage in Children. Not recommended for use in children under 12 years of age.
Precautions. In patients with diabetes mellitus there may be alteration of insulin requirements due to dietary restrictions and weight loss.

Pre-Sate (chlorphentermine hydrochloride) should be used with caution when obesity complicates the management of patients with mild to moderate cardiovascular disease or diabetes mellitus, and only when dietary restriction alone has been unsuccessful in achieving desired weight reduction.

In prescribing this drug for obese patients in whom it is undesirable to introduce CNS stimulation or pressor effect, the physician should be alert to the individual who may be overly sensitive to this drug.

Psychologic disturbances have been reported in patients who concomitantly receive an anorexic agent and a restrictive dietary regimen.
Adverse Reactions. *Central Nervous System:* When CNS side effects occur, they are most often manifested as drowsiness or sedation or overstimulation and restlessness. Insomnia, dizziness, headache, euphoria, dysphoria, and tremor may also occur. Psychotic episodes, although rare, have been noted even at recommended doses. *Cardiovascular:* tachycardia, palpitation, elevation of blood pressure. *Gastrointestinal:* nausea and vomiting, diarrhea, unpleasant taste, constipation. *Endocrine:* changes in libido, impotence. *Autonomic:* dryness of mouth, sweating, mydriasis. *Allergic:* urticaria. *Genitourinary:* diuresis and, rarely, difficulty in initiating micturition. *Others:* Paresthesias, sural spasms.
Dosage and Administration. The recommended adult daily dose of Pre-Sate (chlorphentermine hydrochloride) is one tablet (equivalent to 65 mg chlorphentermine base) taken after the first meal of the day. Use in children under 12 not recommended.
Overdosage. *Manifestations:* Restlessness, confusion, assaultiveness, hallucinations, panic states, and hyperpyrexia may be manifestations of acute intoxication with anorectic agents. Fatigue and depression usually follow the central stimulation.

Cardiovascular effects include arrhythmias, hypertension, or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma.

Management: Management of acute intoxication with sympathomimetic amines is largely symptomatic and supportive and often includes sedation with a barbiturate. If hypertension is marked, the use of a nitrate or rapidly acting alpha-receptor blocking agent should be considered. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendations in this regard.
How Supplied. Each Pre-Sate (chlorphentermine hydrochloride) tablet contains the equivalent of 65 mg chlorphentermine base; bottles of 100 and 1000 tablets.

Full information available on request. PS-GP-31-6W

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An Appeal for Help

Anyone knowing a physician, a hospital, a medical clinic, or other institution, that has successfully treated a patient with progressive bulbar palsy, please write essential details to Edward J. Stevens, editor of the "HEW Newsletter," Room 4233, DHEW North, Washington, D.C. 20201.

It is a motor neuron disease of unknown etiology; a form of amyotrophic lateral sclerosis. The biomedical scientists at NIH diagnosed Ed's condition as progressive bulbar palsy in September, 1970, but the neurosurgeon in charge of his case lost interest once the diagnosis was made. He has no guidance from NIH.

Time is running out since death usually occurs within three or four years after the onset of symptoms. Since the HEW Newsletter is read by 60,000 persons including medical men and administrators of hospitals and clinics throughout the country, Ed thought an appeal like this may give him a clue to a cure of treatment. ("HEW Newsletter," No. 86.)

Beyond Our Reach

One of the most frequently quoted definitions is that from the World Health Organization, that "Health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity." This definition must have emanated from a committee in one of its more euphoric moods, for I doubt whether any one of us is likely to achieve during his lifetime this state of health or, if fortunate enough to achieve it, likely to maintain it for long. Perhaps the committee arriving at this definition had in mind the word of Robert Browning, that "A man's reach should exceed his grasp, or what's heaven for?" For many, however, who try to keep their feet on the ground the inclination would be more to agree with Paget, who when writing to the young Edward VI's Protector warned, "We must not think that Heaven is here, but that we live in a world."

In the world in which we live today there have been very substantial changes since the sixteenth century, and in the case of the female member of the community there has been great progress. (Sir John Peel: "The Health of Women," *British Medical Journal* (July 31) 1971, pages 267-271.)



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Serum Beta Glucuronidase Activity in Juvenile Diabetes Mellitus*

By Howard S. Traisman, M.D., Ronald D. Greenwood, M.D. and James L. Downey, M.D./Chicago

In diabetes mellitus, glucose is inhibited from participation in insulin sensitive metabolic pathways,[1] and glucose utilization is diverted into the non-insulin sensitive glucuronic acid pathway (GAP).[2-4] Present in this GAP is L-xylulose (LX) which has been shown to be increased in the sera of adult diabetics[1,2] when compared to nondiabetics substantiating the increased utilization of glucose in the GAP.

Serum Beta Glucuronidase Activity (SBGA) has been noted by some [5-12] to be elevated in adult diabetics when compared to normals and by others only in female adult diabetics,[13,14] alloxan diabetic rabbits,[15] diabetics and chemical diabetics with vascular disease,[11] asymptomatic chemical diabetics,[16] and possibly also prediabetics.[11]

BG activity, however, also has been found to be increased in the sera of patients with chronic coronary artery disease,[14,17] in atherosclerotic arteries,[18,19,20] in aortic extracts in cholesterol induced atherosclerosis in the rabbit,[21] in the sera of a number of animal species correlated with susceptibility of the species to spontaneous or induced atherosclerosis[22] and possibly increased in other disease states.[9,13,14,15]

The significance of the elevated SBGA is uncertain. It may be only that the increased enzyme activity reflects the increased turnover of mucopolysaccharides or glucuronides related to the complications of diabetes[23] or to coincident disease; or an increased GAP may produce more substrate on which the enzyme must act; or the increase of LX and SBGA both may only reflect the increased degradation of mucopolysaccharides.

Since it has been suggested that the increase in activity of SBGA in diabetic patients reflects the atherosclerotic process itself,[8] children with juvenile diabetes were chosen to be investigated for SBGA.

This paper reports our findings of SBGA in 117 juvenile diabetics.

Materials and Methods

Fifty-four male and 63 female diabetic children (D) ranging in age from 2 to 18¾ years were involved in this study. The mean duration of their disease was 3.7 years. All were receiving insulin. They were matched for age with 107

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Table I. SBGA in Diabetics and Controls

Group	Age 0-4 Years	Age 5-9 Years	Age 10-14 Years	Age 15+ Years	Ages All
C—Males	1.48 ± 0.37 (12)	1.33 ± 0.22 (23)	1.55 ± 0.69 (13)	1.73 ± 0.58 (6)	1.39 ± 0.59 (54)
C—Females	1.57 ± 0.35 (9)	1.55 ± 0.61 (21)	1.61 ± 0.59 (15)	1.45 ± 0.65 (8)	1.55 ± 0.58 (53)
D—Males	1.84 ± 0.56 (7)	2.04 ± 0.71 (19)	2.53 ± 1.37 (23)	2.15 ± 0.86 (10)	2.19 ± 1.02 (54)
D—Females	3.14 ± 1.70 (9)	2.06 ± 0.93 (12)	2.44 ± 1.26 (24)	1.61 ± 0.63 (18)	2.23 ± 1.28 (63)

SBGA expressed as micrograms phenolphthalein liberated per hour per 100 cc. serum, mean ± standard deviation.

Number of subjects in parentheses.

non-diabetic control subjects (C) (54 male and 53 female). Blood was drawn for SBGA and glucose determinations at the time of patient's clinic visit, which was usually 2 to 3 hours postprandial. True blood glucose was determined by the glucose oxidase method (Glucostat®).**

SBGA was determined by the Fishman method[24] and reported as micrograms of phenolphthalein liberated per hour per 100 ml. of serum. The blood was centrifuged at room temperature immediately after being drawn for this determination. The serum was then frozen at 23 degrees Fahrenheit (−5 degrees Centigrade) until the time of assay.

Results

The results of the SBGA in various age groups on both diabetics and controls are shown in Table I. A significant difference ($p < .001$) was found when all the diabetic males were compared with all the control males, and when all the diabetic females were compared with all the control females.

Table II shows the lack of relationship between the duration of the diabetes mellitus and SBGA.

In Table III, the relationship between SBGA and the degree of control as previously defined[25] is seen. Significant differences are demonstrated between good control in female patients and poor control ($p < .001$). In contrast, the relationship between SBGA in the male patients with degree of control is probably not significant (p slightly above .05).

In Table IV, the relationship of SBGA and blood sugar is shown. A slightly significant difference ($p = .05$) is shown for diabetic males and

Table II. SBGA and Duration of Diabetes

Group	Less Than 3 Years	3 Years or Longer
D—Males	2.07 ± 1.09 (26)	2.28 ± 0.96 (28)
D—Females	2.26 ± 1.49 (31)	2.20 ± 1.20 (32)

SBGA expressed as micrograms phenolphthalein liberated per hour per 100 cc. serum, mean ± standard deviation.

Number of subjects in parentheses.

Table III. SBGA and Degree of Control of Diabetes

Group	Good	Poor
D—Males	1.87 ± 0.93 (23)	2.40 ± 1.04 (31)
D—Females	1.54 ± 0.41 (26)	2.55 ± 1.66 (37)

SBGA expressed as micrograms phenolphthalein liberated per hour per 100 cc. serum, mean ± standard deviation.

Number of subjects in parentheses.

Table IV. SBGA and Blood Glucose

Group	Below 200	200 and Above
C—Males	1.39 ± 0.59 (54)	
C—Females	1.55 ± 0.58 (53)	
D—Males	1.84 ± 0.96 (21)	2.39 ± 1.01 (33)
D—Females	1.97 ± 1.46 (22)	2.37 ± 1.16 (41)

SBGA expressed as micrograms phenolphthalein liberated per hour per 100 cc. serum, mean ± standard deviation.

Number of subjects in parentheses.

**Worthington Biochemical Corp., Freehold, N.J.*

control males both with sugars below 200 mg%; a significant difference ($p<.05$) exists for diabetic males below 200 mg% when compared with diabetic males with blood sugars above 200 mg%. Comparison of females, however, was not significant.

Discussion

We have found elevated SBGA in juvenile diabetics. This elevation may be a true feature of diabetes mellitus, i.e., increased utilization of a metabolic pathway non-sensitive to insulin, for it is seen in children with relatively short duration of their disease. It may also represent a biochemical process to prevent deposition of polysaccharide in the vasculature of the diabetic[26] or may be an indicator of the atherosclerotic process itself. Since there appears to be a relationship between SBGA and degree of control, this might support the hypothesis of glucose diversion.

Summary

One hundred-seventeen (117) juvenile diabetics had elevated SBGA. Patients who were not well controlled had a significant higher elevation of SBGA than those diabetics who were well controlled. The clinical significance of SBGA has been briefly reviewed.

Acknowledgements:

We wish to thank Orville C. Green, M.D. and Henry L. Nadler, M.D., for commenting on the manuscript. ◄

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A complete bibliography of "Serum Beta Gylucuronidase Activity in Juvenile Diabetes Mellitus," is available through the *Illinois Medical Journal,* 360 N. Michigan Ave., Chicago, 60601, or call (312) 782-1654.

Twenty-Nine Clinics For Crippled Children Listed for April

Twenty-nine clinics for Illinois' physically handicapped children have been scheduled for April by the University of Illinois, Division of Services for Crippled Children. The Division will have twenty-one general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social, and nursing services. There will be six special clinics for children with cardiac conditions, and two for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

April 3 Alton—Alton Memorial Hospital
April 4 Rock Island Cerebral Palsy—Foundation for Crippled Children and Adults
April 4 Hinsdale—Hinsdale Sanitarium
April 4 Metropolis—Massac Memorial Hospital
April 5 Sterling—Sterling Community Hospital
April 5 Lake County Cardiac—Victory Memorial Hospital
April 5 Effingham—St. Anthony Memorial Hospital
April 5 Springfield—St. John's Hospital
April 9 Peoria Cardiac—St. Francis Children's Hospital
April 10 Peoria—St. Francis Children's Hospital
April 11 Champaign-Urbana—McKinley Hospital
April 12 Kankakee—St. Mary's Hospital
April 13 Chicago Heights Cardiac—St. James Hospital
April 17 Rock Island—Moline Public Hospital
April 17 E. St. Louis—Christian Welfare Hospital
April 17 Quincy—St. Mary's Hospital
April 18 Chicago Heights—St. James Hospital
April 19 Elmhurst Cardiac—Memorial Hospital of DuPage County
April 19 Bloomington—Mennonite Hospital
April 19 Rockford—Rockford Memorial Hospital
April 19 Cairo—Public Health Department
April 23 Peoria Cardiac—St. Francis Children's Hospital
April 24 Peoria—St. Francis Children's Hospital
April 24 Mt. Vernon—Park Avenue Baptist Church
April 25 Aurora—St. Joseph Mercy Hospital
April 25 Centralia—St. Mary's Hospital
April 25 Springfield Pediatric-Neurological—Diocesan Center
April 27 Evanston—St. Francis Hospital
April 27 Chicago Heights Cardiac—St. James Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective, and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling.

Nystatin Vaginal Cream in Monilial Vaginitis

By John H. Isaacs, M.D./Skokie

Nystatin in tablet form is a widely used agent in the therapy of vaginal candidiasis.[1-4] The initiation of studies of a new investigational nystatin vaginal cream* presented an opportunity for re-evaluation of this common therapy. This investigation on monilial vaginitis caused by *Candida albicans* was conducted by the double-blind method, using a coded drug supply of nystatin and placebo with final statistical analysis.

Method

This double-blind coded study was designed to evaluate efficacy and safety of nystatin vaginal cream compared with placebo cream in the treatment of monilial vaginitis in 50 adult female patients. Twenty-five individuals were assigned to each group. Randomization with respect to age was satisfactory; the average age was 30.1 years for those on nystatin and 30.3 for the placebo medication. The ages ranged from 17 to 51 and from 19 to 43, respectively. All patients presented with clinical history and findings suggestive of *Candida albicans* vaginitis. The diagnosis was confirmed by wet smears using a 10% solution of potassium hydroxide plus cultures of the vaginal secretions. Coexistent diseases included acute vulvitis (1) and herpes progenitalis (1) in the placebo group; and acute vulvitis (1), cystitis (1), and trichomonas infestation (3) in the nystatin group. Six of those treated with the placebo and two with nystatin were pregnant. Patients were asked to avoid sexual intercourse during the study.

Each patient (save one in the nystatin group) applied the cream to the vagina twice a day. Each application consisted of 5 Gm of placebo cream or 5 Gm of nystatin cream (100,000 units per gram). Duration of therapy was 14 days in 14 placebo cases and in 20 of the nystatin cases. The average duration was 12.6 days for nystatin and 11.1 days for placebo; this was not a significant difference.

In the placebo group three patients were on steroid vulver ointment; two on oral contraceptives; and one used idoxuridine for herpes. In the nystatin group; two were on oral contraceptives; one on estrogen replacement therapy; one on a progestational agent; one on sulfamethoxazole with phenazopyridine-HCl; and three were under therapy for trichomonas infestation with metronidazole.

If any patient was considered worse at time of first check-up visit (day 4 to 7), culture was to be taken and the patient put on known nystatin therapy. This was considered necessary in three of those on placebo medication and in none on nystatin. Cultures were taken on all patients initially and on most patients during therapy and at four to seven days post therapy. The overall clinical responses were evaluated and side effects noted.

All results were analyzed statistically using the chi-square test.

Results

The overall clinical response was significantly better in the nystatin group, being rated "good" to "excellent" in 23 of 25 (92%) versus 15 of 25 (60%) for those taking placebo medication (chi-square = 10.55, p = 0.005). Those 25 patients who received nystatin showed an excellent response in 15 and a good response in 8; two had a poor response. In the placebo group, the clinical response was excellent in 5, good in 10, and poor in 10. No patient in either group became worse. These results are presented in Table 1.

**Nilstat® Nystatin Vaginal Cream a registered trademark of Lederle Laboratories Division, American Cyanamid Company, Pearl River, New York.*

This study was made possible by Grant No. 1613 from Lederle Laboratories.



John H. Isaacs, M.D., is clinical professor in the Department of Obstetrics and Gynecology, Loyola University Stritch School of Medicine and consultant on the staff of Mercy Hospital and Lutheran General Hospital, Chicago. A graduate of St. Louis University School of Medicine, Dr. Isaacs is a former president of the Chicago Gynecological Society and he is a fellow of the American College of Surgeons and a member of its Board of Governors. Dr. Isaacs is also Director of the Department of Gynecologic-Oncology.

Table 1. Clinical Response to Vaginal Cream

Unknown	*Clincal Response*				*Total*
Preparation	*Excellent*	*Good*	*Poor*	*Worse*	*Number*
Nystatin	15	8	2	0	25
Placebo	5	10	10	0	25
Totals	20	18	12	0	50

Chi-square = 10.55, p = 0.005

Table II. Bacteriological Response to Vaginal Cream

Unkonwn	*Bacteriological Response*								
	Pre-Therapy			*During Therapy*			*Post-Therapy*		
Preparation	+	−	*Total*	+	−	*Total*	+	−	*Total*
Nystatin	25	0	25	3	18	21	6	16	22
Placebo	25	0	25	9	12	21	15	4	19
Totals	50	0	50	12	30	42	21	20	41
					Chi-square = 2.91 p = 0.088			Chi-square = 8.93 p = 0.003	

All cultures taken before treatment were positive for *C. albicans*. Cultures taken during therapy at four to seven days showed a persistent positive culture in 3 of 21 patients in the nystatin group and in 9 of 21 patients in the placebo group (chi-square = 2.92, p = 0.088). Post therapy cultures (taken 4 to 7 days after treatment), showed significantly more clearing in those patients who had taken nystatin than in those on placebo (chi-square = 8.93, p = 0.003). Only six of 22 (26%) remained positive in the nystatin group; 15 of 19 (79%) remained positive in the placebo group. See Table II.

The three patients who were switched from placebo to known nystatin on the seventh day all had relief of symptoms; only one of their post therapy cultures converted to negative. One patient on nystatin cream reported a minor side effect of "burning of the vulva". This did not necessitate discontinuance of therapy.

Comments

In this double-blind study of 50 adult female patients having confirmed *Candida albicans* vaginitis, the antifungal agent nystatin was shown to be significantly superior to placebo medication as evidenced by both clinical and mycological responses. The safety and efficacy of nystatin vaginal cream when administered twice daily by applicator for the treatment of monilial vaginitis has been demonstrated.

Summary

In this double-blind randomized study of nystatin and placebo vaginal cream, 50 adult female patients were treated twice daily for two weeks. The overall clinical response was significantly better in the nystatin group, being "good" to "excellent" in 23 of 25 (92%) versus 15 of 25 (60%) for the placebo group. The mycological response at four to seven days post therapy was also significantly better for the antibiotic with only 6 of 22 (26%) patients on nystatin remaining positive, while 15 of 19 (79%) of those who were on placebo remaining positive. ◄

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Pacemaker Experiences in Small Community Hospitals

By Hugh S. Espey, M.D./ Quincy

This is a report on 35 patients who were treated for heart block or slow ventricular rate by the installation of permanent pacemaker between the dates of September, 1966 and March, 1972. These services were rendered in general hospitals of 230 to 250 beds without house staff and with facilities comparable to those of the vast majority of hospitals throughout the country.

Type of Arrhythmia

3° AV block (permanent)	21 cases
3° AV block (intermittent)	4 cases
2° AV block	5 cases
Bradyarrhythmia (sinus brady., atrial fib.)	4 cases
Ventricular asystole	1 case
Total	35 cases

Age and Sex

40 to 49	1 case
50 to 59	2 cases
60 to 69	5 cases
70 to 79	15 cases
80 to 89	12 cases

There were 18 males and 17 females in this group.

Clinical Picture

Twenty of the 35 cases presented the Adams-Stokes syndrome, which Friedburg defines as "attacks of syncope with or without convulsive seizures due to severe bradycardia (less than 20 per minute) or prolonged asystole (5 second or more.)"[1] The majority of our cases had syncope from once to a great number of times. Some patients were aware they had lost consciousness while others had amnesia for this event. In several instances there were injuries resulting from syncope; for example, fractured nose, fractured clavicle.



HUGH S. ESPEY, M.D., is director af Hemadialysis Unit, Blessing Hospital, Quincy, and maintains a practice in internal medicine at the Physicians & Surgeans Clinic, Quincy. He is a Fellaw af American Callege af Physicians and Fellow of American College of Cardiolagy.

The other major type of presenting complaint was that the physical incapacity ranging from marked reduction of capacity for effort to enforced bed rest because of weakness and faintness.

Adams-Strokes syndrome (syncope)	20 cases
Bradyarrhythmia without syncope	15 cases

Cases With Syncope

Two of the 20 cases in this category first manifested syncope while driving an automobile, one with a permanent 3° AV block and the other with an intermittent 3° AV block. In 15 of the 20 cases we were able to document 3° AV block. The following chart shows the breakdown by recognized arrhythmia.

Permanent 3° AV block	14 cases
Intermittent 3° AV block	1 case
2° AV block	1 case
Sinus bradycardia	2 cases
Slow atrial fibrillation	1 case
Ventricular asystole	1 case
Total	20 cases

It is quite possible that either transient ventricular asystole or 3° AV block could have been demonstrated in all these cases had we been able to monitor the electrocardiogram continuously. One of these cases originally had what appeared to be a permanent 3° AV block with repeated episodes of syncope. Following the insertion of a fixed-rate pacemaker, a normal sinus rhythm was established within a year and remained so for another two years. During the time of normal sinus rhythm we found continuous competition between the fixed-rate pacemaker and the patient's SA node, with the rhythm changing every 4-5 beats from normal sinus rhythm to paced rhythm. This was well tolerated for 24 months, at which time the batteries became exhausted and the patient showed a perfectly normal sinus rhythm. Fortunately, it was elected to replace the exhausted pulse generator with a new demand pulse generator for within a year the 3° AV block reappeared, necessitating regular pacing.

Cases Without Syncope

3° AV block (permanent)	10 cases
3° AV block (intermittent)	1 case
2° AV block	4 cases
Total	15 cases

Note that all these cases were severely handicapped by their bradyarrhythmia. According to the functional classification by the New York Heart Association the majority were in Class IV and the remainder in Class III.[2] Congestive heart failure was a frequent finding in this group. First-degree AV block was found commonly, but it was not felt to be of importance insofar as cardiac function was concerned, and, therefore, this finding is not tabulated.

Congestive Heart Failure

Eleven of the 35 cases showed congestive heart failure on admission to the hospital. In all cases, there was prompt clearing of failure following the institution of cardiac pacing without the use of diuretic or digitalis.

Etiology

In 34 cases, arteriosclerotic disease was the basic etiologic factor. In one case, granulomatous myocarditis was found to be the cause. This single case will be mentioned in more detail under the paragraph entitled "Malfunction of Electrode."

Type of Pacemaker

Of the 35 original pulse generators, 32 were of the demand type and 3 fixed-rate. There are now 14 of our cases who are using their second pulse generator; five, their third pulse generator; and one, his fourth pulse generator. The reasons for replacement will be tabulated under "Malfunction of Pulse Generator." This represents a total of 63 demand pulse generators and 8 fixed-rate in type.*

In those individuals where fixed-rate pulse generators were used (with the exception of our first case and one of the other very early cases), it was originally felt that if an individual had a permanent 3° AV block as far as we could tell, a fixed-rate pacemaker was indicated. Our feeling about this has been modified considerably; it is now our feeling that a demand pulse generator is almost always preferable. We have found that usually these individuals show a sufficient number of premature contractions to warrant a demand pulse generator. Furthermore, there is reported to be some danger of producing a serious arrhythmia should the pacing artefact fall on the T-wave. As a matter of fact, however, it appears from our observations that the likelihood of this occurring is remote unless the patient has a failing myocardium, serious electrolyte imbalance or digitalis intoxication. Therefore, we have not been particularly concerned otherwise about the hazard of the pacing stimulus falling on the T-wave of the premature contraction as long as the patient was doing well.

Two of the fixed-rate were manufactured by the Electrodyne Co., the remaining all by Medtronic, Inc.

Our one patient who has had four pulse generators has had two fixed-rate and two demand types. His initial fixed-rate pulse generator was replaced at the end of one year due to a failure of function (which in the final analysis was probably electrode failure). The second (a demand) pulse generator failed after 23 months and was replaced by another demand pulse generator which failed in five weeks, because of a failure of separation between inner and outer cases of one battery cell, causing an open circuit which resulted in "no output." His fourth pulse generator was replaced in April, 1970, and continues to function well, although we are seeing an undesirable number of premature contractions appearing irregularly and our decision now would be to not use a fixed-rate pulse generator in this individual again.

Type of Electrode

In two instances a myocardial electrode was implanted initially and the remaining 33 endocardial electrodes passed by the transvenous route. All of the endocardial electrodes were bipolar. In our first case in September, 1966, we probably would have fared better with an endocardial electrode. However, such an electrode was not commonly used at that time. A myocardial electrode was initially chosen in another case because the individual was quite vigorous, and appeared and acted much younger than her 69 years. It was felt there would be less problem with the electrode over the course of time and therefore the myocardial electrode was used initially. Although it has been eminently satisfactory in this case, I do not believe we would make the same decision were we to be faced with this problem today.

There were three other cases which originally had endocardial electrodes which failed to pace continuously for various reasons and which were replaced by myocardial electrodes. In two of these, the failure was found to be due to perforation of the ventricle by the electrode. There was irregular pacing after two months with ap-

parent change in position of the electrode tip in the remaining case. Rather than attempt pacing with endocardial electrodes again, it was elected to use the myocardial electrode which functioned well. There was one other case in which there was electrode failure after nine months due to undetermined cause, in which event the original electrode was forcibly removed and another endocardial electrode was passed transvenously. There were, therefore, five cases in which initially or eventually myocardial electrodes were used; in the remaining 30 cases, endocardial electrodes proved quite satisfactory, the earliest one having been placed on June 4, 1967, and still functioning well at age 88. However, it is worthy of note that in our last 25 cases we have not used a myocardial electrode; the last time this was used was in February, 1969.

Results

There have been six cardiac deaths in this group of 35 patients. Four of these deaths occurred within six months, three being due to arteriosclerotic heart disease and one with granulomatous myocarditis. Two additional deaths occurred due to arteriosclerotic heart disease between the 27th and 37th months after pacemaker implantation. There have been two deaths due to non-cardiac causes.

In retrospect, it is felt that there were five cases with poor results. The first of these was our initial case which expired after two months due to an unfortunate series of complications, with the patient not being rehabilitated, nor was her cardiac function appreciably improved except that she did cease having repeated episodes of Adams-Stokes syndrome. The second and third cases expired due to congestive heart failure after five months and six months respectively. Case number four died in 3 months suddenly and unexpectedly with granulomatous myocarditis. The remaining case, that should be classed as a poor result, is a woman with severe impairment of cardiac function (class III) who is living, but with marked restriction of activities after 24 months.

Temporary Pacing

Thirteen cases were paced temporarily prior to the implantation of a permanent pacemaker. In six of these it was felt that there was some question as to what might be expected from pacing: it was hoped that by temporary pacing for a few days we might better evaluate what long-term result we might expect. Four additional cases presented rather severe congestive heart failure on admission and it was felt that by temporary pacing we could improve their general condition, which proved to be the case. In the remaining three cases temporary pacing was used as an emergency procedure because of severe Adams-Stokes syndrome accompanied by repeated convulsive seizures. Following control of this problem, permanent pacemakers were installed.

In the light of our present experience, the initial six people in which we "tested" their response to pacing, we would now probably handle these cases differently and proceed directly with permanent implantation of a pacemaker.

Surgical Procedures and Other Complications

A variety of surgical procedures have been performed after the permanent pacemakers have been installed. Three cases have had cataract surgery and another three cases have had transurethral prostatic resections. Two individuals have had surgery for fractured hips. The following surgical procedures have been performed in single cases in our series; hydrocelectomy, vagotomy with pyloroplasty due to gastrointestinal hemorrhage from duodenal ulcer, left renal colic with cystoscopic examination (twice in one patient), appendectomy, femoral artery thrombosis with amputation of extremity. Other unrelated non-surgical complications consisted of major pulmonary embolism, acute cholecystitis and upper gastrointestinal hemorrhage without surgical intervention.

It is of note that in three cases the ventricular wall had been perforated by the electrode. In one instance a temporary pacemaker was installed as an emergency because of repeated episodes of cardiac arrest; when the permanent pacemaked was implanted 36 hours later the temporary electrode was seen to be perforating the myocardium and the tip of the electrode was visible externally. In two cases the permanent endocardial electrode perforated the heart, one in six days and another after 21 days.

Malfunction of Electrode

Four of the cases had a total of ten electrode mechanical malfunctions. In three of these cases, there was early failure of pacing in from two days to three weeks; and in all of these, repositioning of the electrode led to satisfactory pacing for a time. In one of these three cases, there was again failure to pace after ten months, which was thought to be due to electrode failure although this could not be proven with certainty; and after removal of the original endocardial

electrode and introduction of another similar electrode, the patient has been paced very satisfactorily for the last four years. The second of these three cases where the electrode was repositioned initially, there was again failure to pace regularly after six weeks and this electrode was then replaced with a myocardial type of electrode. In the third of these three cases there was again failure of pacing after three weeks, at which time a myocardial electrode was placed and it was found at surgery the pacing failure was due to perforation of the ventricle by the electrode. This last case, incidentally, subsequently had another failure due to break in the wire of one electrode, at which time an indifferent lead was attached to the pulse generator making it of unipolar type. This functioned for a few months but again failed to pace; this was finally corrected by repairing the electrode break and re-instituting bipolar pacing.

In the fourth case, a temporary endocardial electrode was originally used for an emergency because of repeated Adams-Stokes syndrome with convulsion. On the following day a permanent endocardial electrode was placed, but this failed after less than 24 hours, and the patient then was paced with the temporary electrode for a matter of six days. At that time, due to failure of the temporary electrode to pace, a myocardial electrode was put in place and at surgery it was found that the original electrode had perforated the heart. He continued to do well for 22 months, after which time, following an injury and blow to the abdomen, there was failure to pace and it was found at surgery that he could be paced through only one electrode, indicating a break in the other electrode wire. It was necessary to convert this to unipolar pacing by the use of an indifferent electrode to the pulse generator, and since then the patient has done well.

There was a fifth case of electrode failure due to pathology within the heart. This was a 56-year-old lady troubled with periods of weakness, dyspnea, and bradycardia of recent onset as well as signs of congestive heart failure. The blood pressure was 160/84, the heart rate 38 with 3° AV block. The heart was not enlarged as seen on X-ray. A demand pulse generator was implanted with an endocardial lead and she was paced satisfactorily except for an occasional premature contraction. Cardiac arrest occurred suddenly three months later with sudden death resulting. Autopsy revealed the entire septum to be involved in inflammatory disease and the pacemaker electrode was surrounded by granulomatous inflammatory tissue. The pathology diagnosis was "extensive granulomatous myocarditis."

Malfunction of Pulse Generator

There have been 16 pulse generator failures involving 13 individuals, 14 of these failures being due to battery exhaustion and two due to pulse generator problems. In one of these, an Electrodyne fixed-rate pulse generator became exhausted after 23 months; the remaining were Medtronic pulse generators which failed with two exceptions between 20 and 26 months. In the cases of battery exhaustion, there was complete failure of pacing in five and rate change in nine cases. The two exceptions mentioned above consisted of an intrinsic defect within the pulse generator resulting in an open circuit and failure within five weeks, and the other to a defective set screw resulting in pacing failure after four days.

In the remaining 14 cases the failure in function was manifested by failure to pace in five cases, decrease in rate in eight cases, and an increase in rate in one case (from 73 to 82 per minute.) Analysis by the manufacturer thereafter showed 60% total depletion by X-ray as well as a depletion of two battery cells in this last case.

Communication from the manufacturer** has recommended elective replacement after a given number of months. This has been done in seven cases; two of the seven longer than the recommended 24 months, one 29 months, and one 30 months; and in all seven, there was no clinical evidence of failure at any time.

Summary

This is a report on 35 cases treated by the use of permanently implanted pulse generators as pacemakers. Twenty of the 35 cases had syncope; the remaining cases had varying degrees of weakness due to bradyarrhythmias. Congestive heart failure was a common finding and responded well to pacing. Battery life has been in the neighborhood of 21 to 30 months. Medtronic pulse generators were used in all except two early cases in which Electrodyne equipment was used. The great majority had demand pulse generators which, from our observation, usually are superior to the fixed-rate type. Elective replacement of the pulse generators according to the manufacturers' recommendations, together with clinical observation of sufficient frequency to detect impending failure should allow replacement of pulse generators before

**Medtronic Company

(Continued on page 292)

Supernumerary Intrathoracic Ribs

By Christopher A. Lekas, M.D. and Lawrence E. Lee, M.D./Evergreen Park

The supernumerary intrathoracic rib is an anatomical curiosity of rare incidence. A recent survey of the literature revealed slightly more than a dozen reported cases. Roentgenologic detection of this anomaly in a twenty-month-old white female prompted this report because 1) this anomaly is asymptomatic in most cases, and 2) this anomaly may be mistaken on chest roentgenogram for a tumor or other more serious chest pathology. This paper presents a case report plus a review of the literature.

Case Report

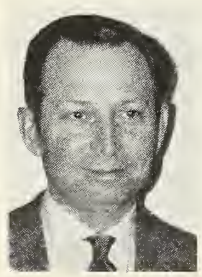
A twenty-month-old white female was admitted to Little Company of Mary Hospital, because of a four day fever of unknown origin. History and physical examination suggested an upper respiratory tract infection. Past history was significant in that initial chest roentgenogram at birth, at another hospital, revealed an obscure shadow in the right lung field. The impression was that the shadow represented an aberrant blood vessel. The infant was closely followed clinically. Her growth and development were within normal limits.

On the present admission, the physical examination was negative except for nasopharyngeal catarrh. Laboratory workup including CBC with differential and a heterophil antibody test was within normal limits. An intravenous pyelogram was normal. The chest X-ray, PA and lateral views (Fig. 1), revealed a curvilinear density extending laterally from the level of the sixth thoracic vertebra and curving inferiorly to blend with the left hemi-diaphragmatic shadow. This structure had the same density as the adjacent ribs. Antero-posterior laminograms (Fig. 2) clearly delineated the structure to be a supernumerary intrathoracic rib with diaphragmatic attachment. The infant was discharged in good health one week later with a final diagnosis of viral upper respiratory tract infection.

Discussion

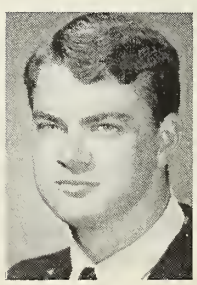
This case and most of the previously reported cases have been characterized by being asymptomatic, and thus diagnosed as an incidental finding. Supernumerary intrathoracic ribs are usually unilateral, solitary and not uncommonly with diaphragmatic attachment. There is no definite sex prevalence.

Several authors have proposed embryological etiologies for supernumerary intrathoracic ribs. Ribs begin as costal processes growing away from the primitive vertebral masses and extending into the clefts between the myotomes. These mesenchymal "rib" masses acquire a chondrification center about the seventh fetal week, becoming a cartilagenous mass. Primary ossification centers appear during the ninth fetal week, near the angles of the ribs, prior to the beginning of ossification in the corresponding vertebrae. Ossifica-



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Lawrence E. Lee, M.D. (right) was a resident in radiology at Little Company of Mary. He holds a B.S. in Chemistry from St. Louis University and the M.D. from the University of Illinois College of Medicine.



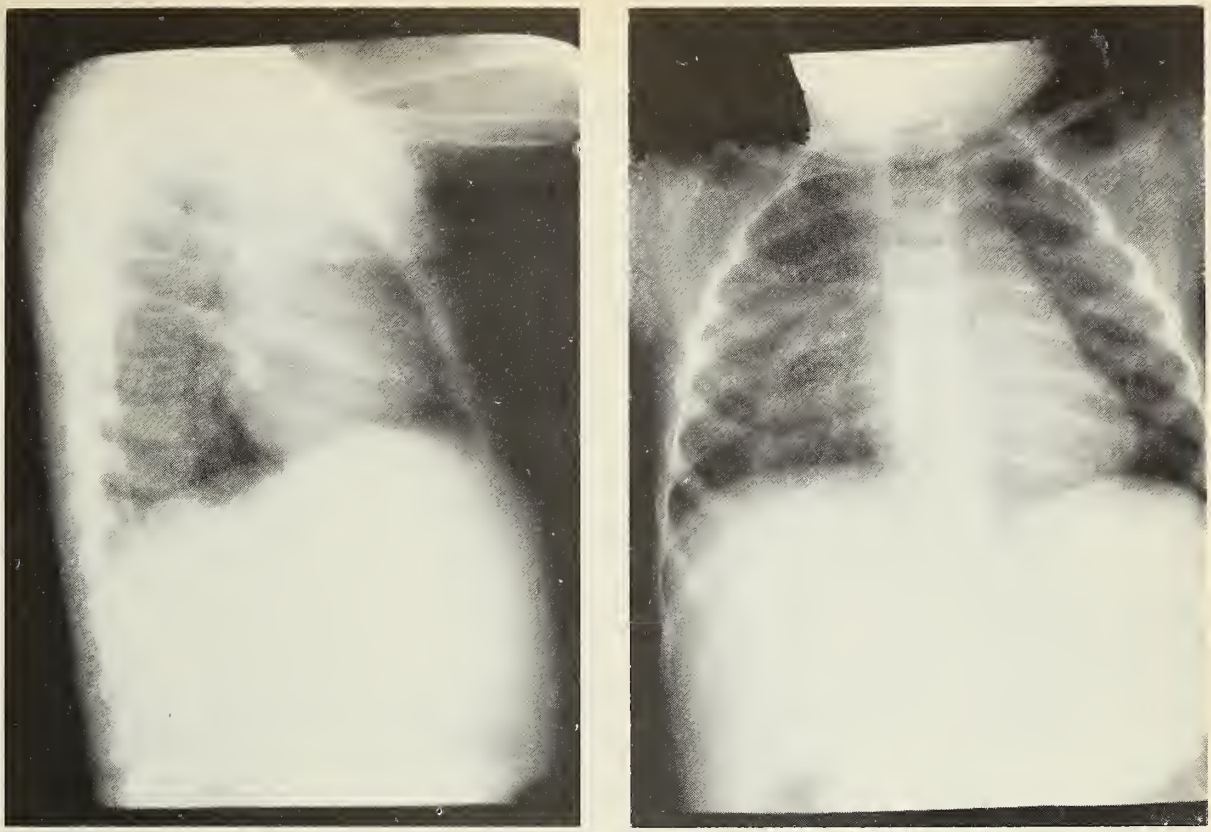


Fig. 1. Posterioanterior (right) and Lateral Chest Roentgenograms Showing the Right Intrathoracic Rib.

tion extends rapidly forward so that the shafts are ossified and surround the greater part of the thorax as thin bony strips by the end of the fourth fetal month. The best theory thus far is that failure of fusion between component halves of adjacent sclerotomes results in formation of two lateral processes on the affected side. These lateral processes develop into two ribs, one rib articulating with a vertebral body and the second rib with the postero inferior margin of a normal rib.

Roentgen diagnosis should not be difficult if supernumerary intrathoracic rib is included in the differential diagnosis of chest lesions. A routine chest X-ray demonstrating an obscure shadow or definite density of rib consistency arising in the postero-medial thoracic region and extending inferolaterally toward the diaphragm on the same side should arouse suspicion. When the diaphragm is attached to this rib, it produces tenting of the diaphragm or a triangular shadow in the lung base. Laminography, over-exposed roentgenograms, and stereoscopic films of the chest will demonstrate the density articulating with a vertebra or ribs and thus make the diagnosis of supernumerary intrathoracic rib.

Table I reveals clinicopathologic aspects of several reported cases of supernumerary intrathoracic rib.

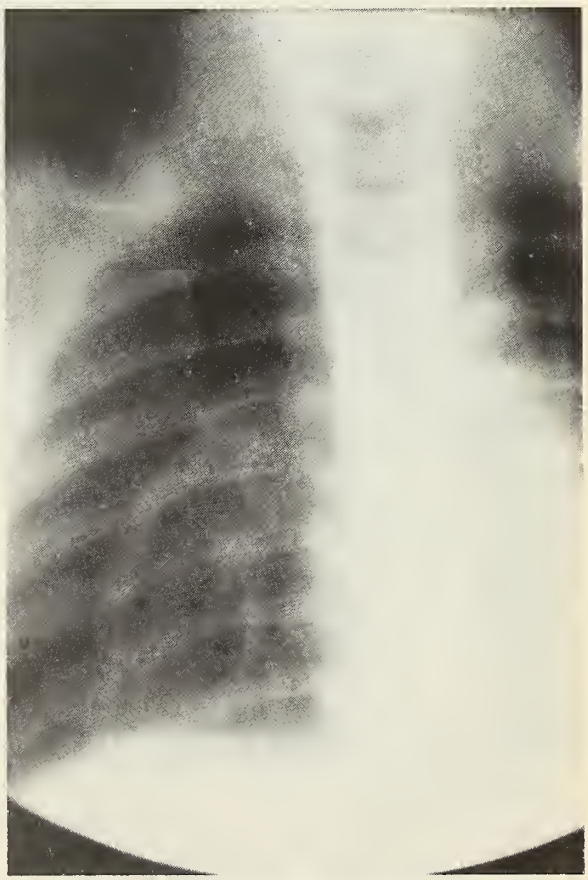


Figure 2. Anterioposterior Chest Laminogram, Clearly Showing the Right Intrathoracic Rib.

TABLE I

Case	*Sex*	*Age*	*Side of Rib*	*Site of Rib*	*Pleural Space*	*Remarks*
Jacobs[5]	M	43	R	T-3	Normal	First autopsy proven case
Marbut & DeGinder[9]	F	20	R	T-6:7	Normal	Produced severe R. shoulder pain
Stevenson & Merendino[13]	F	17	R	T-6:7	Fibrous attachment to right hemidiaphragm	Massive tenting of R. hemi-diaphragm
Allan[2]	M	60	R	Normal	Two trans pleural muscles from 6th thoracic rib to dome of diaphragm	Asymptomatic; mistaken for pleural adhesion
Lutz[7]	F	25	R	Incomplete bifid 4th thoracic rib	Inf. branch attached to diaphragm	L. sided pain; 1st description of supernumerary intrathoracic rib
Plum[10]	F	9	R	T-6	Extrapleural	Surgically removed
Wilk & Hulshoff[18]	M	12	L	T-6		1st left sided rib
Whitlark & Engels[17]	F	14	L	T-5		R. sided aortic arch
Stevenson & Merendino[13]	M	39	L	Normal	Tendinous bands from ant. surface of 2nd thoracic rib to diaphragm	
Weinstein & Muller[15]	M	23	R	Lower T		
Shoop[12]	F	28	L	T-3		Transthoracic from post. L. 3rd rib to ant. L. 2nd rib
Von Ronnen & deJongh[14]	F	8	R			Ophthalmic scrofula
Von Ronnen & deJongh[14]	M	5	R	T-5	Attached to diaphragm	

Summary

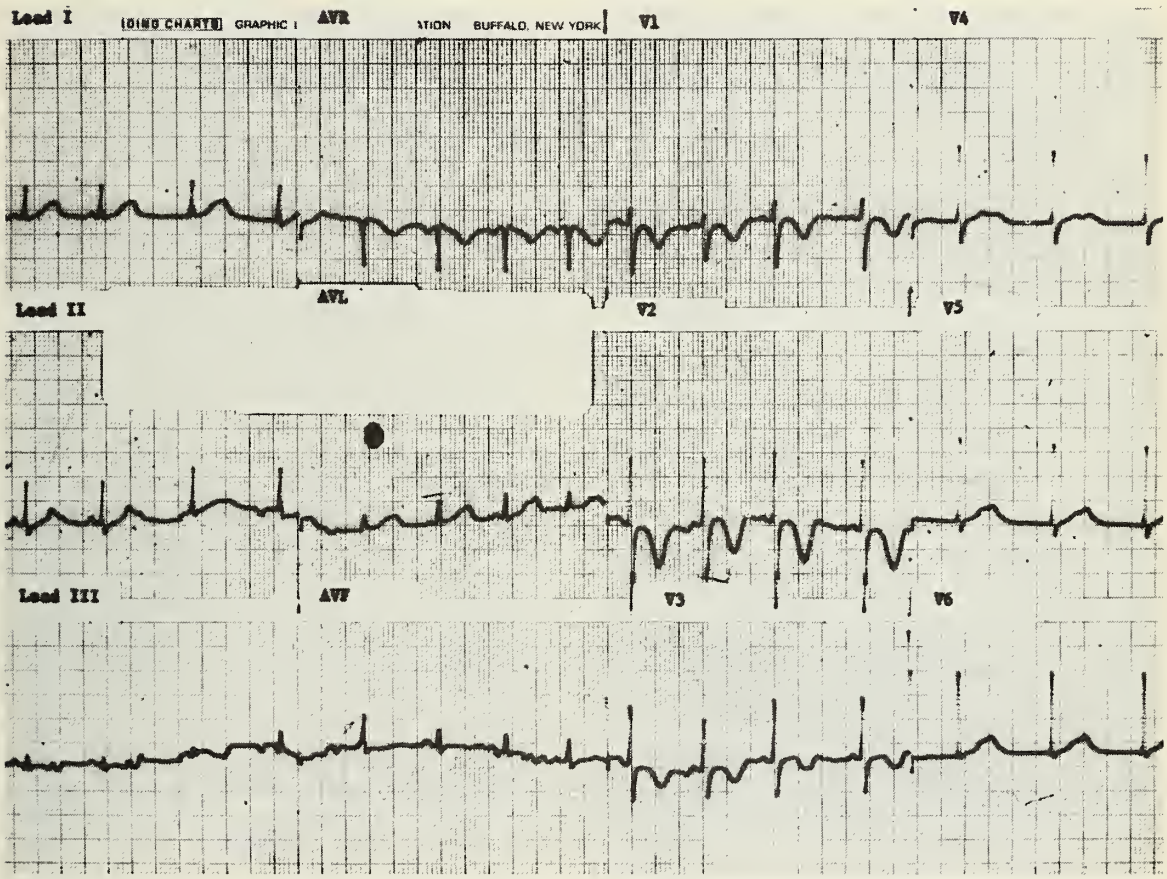
Supernumerary intrathoracic rib is a rare thoracic cage anomaly seen in asymptomatic (usually) patients. Awareness of this entity allows the radiologist to make an "esoteric" diagnosis as well as lengthening his differential diagnosis of obscure chest lesions. ◄

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ekg of the month

John R. Tobin, Jr., M.D., M.S., Rimgaudas Nemickas, M.D., Patrick Scanlon, M.D., John F. Moran, M.D., and James V. Talano, M.D./ Section of Cardiology, Loyola University Stritch School of Medicine



This is a three-year-old white male admitted to hospital with the diagnosis of internal hydrocephalus for multiple revision of ventriculojugular shunts. A routine admission ECG was taken.

A. This electrocardiogram demonstrates:

(1) Sinus arrhythmia.
(2) Abnormal repolarization changes (T-wave changes) in the precordial leads.
(3) Periods of junctional rhythm.
(4) Non-conducted atrial beats.
(5) All of the above.

B. The repolarization abnormalities (T-wave changes) of this kind could be seen in a patient:

(1) with myocardial ischemia from coronary artery disease.
(2) on psychotropic drugs.
(3) with elevated intracranial pressure.
(4) with viral myocarditis.
(5) all of the above.

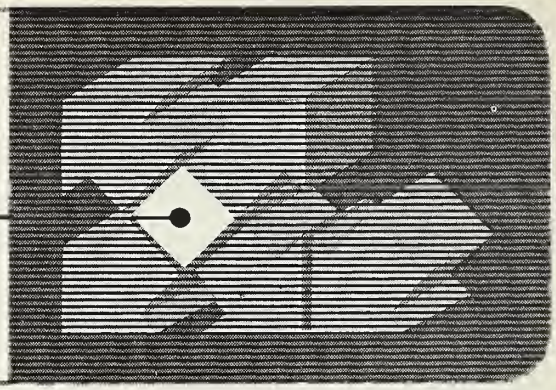
C. The most likely explanation for these T-wave changes in the above patient is:

(1) Myocardial ischemia from coronary artery disease.
(2) Psychotropic drugs.
(3) Elevated intracranial pressure.
(4) Viral myocarditis.

(Answers on page 282)

Trauma Center

David R. Boyd, M.D.C.M., Editor



Cardiac Rupture Secondary to Blunt Trauma

By Adolph M. Lo, M.D. and Gregory Van Stiegmann/Champaign

Increased numbers of high speed automobile accidents have led to a concurrent increase in blunt trauma to the chest, more commonly known as "steering wheel" injuries. Cardiac damage from such trauma may range from mild contusion to cardiac rupture, with other possibilities, including coronary vessel injury, rupture of interventricular or intra-atrial septa, damaged chordae and valves, and complex fistulae formation. While many of the above injuries may lead to rapid decompensation, prompt transportation to hospital facilities and early diagnosis can result in increased survival rates. The case presented illustrates the successful surgical repair of a ruptured left atrium secondary to blunt trauma.

Case Report

This 69 year-old man was in shock on admission to the Emergency Room of Burnham City Hospital Regional Trauma Center, Champaign. He had been involved in a head-on automobile collision and had sustained blunt trauma to the chest. His blood pressure was 60 mm. Hg. systolic with paradoxical femoral pulses. He had bilateral flailing of the chest, and his face and neck were dusky and cyanotic, with severe distention of the neck veins. Breath and heart sounds were faint, and occasionally not audible. The abdomen was flat and soft, and lacerations were present on the forehead and right knee.

The patient was intubated immediately and given mechanical respiratory assist. Chest X-ray demonstrated multiple fractured ribs on the left side with a 30% pneumothorax. The superior mediastinum was widened, and there was suggestion of increased heart size with pneumopericardium. A central venous pressure catheter was inserted through the right subclavian vein, and a recording of 30 cm. water pressure was obtained. Chest tubes were then inserted bilaterally.

Based on the extremely high central venous pressure and paradoxical pulse, a diagnosis of pericardial tamponade was made. The patient was transferred immediately to the operating room, where, upon arrival, blood pressure was unobtainable. A left anterolateral thoracotomy was made in the fourth intercostal space. The



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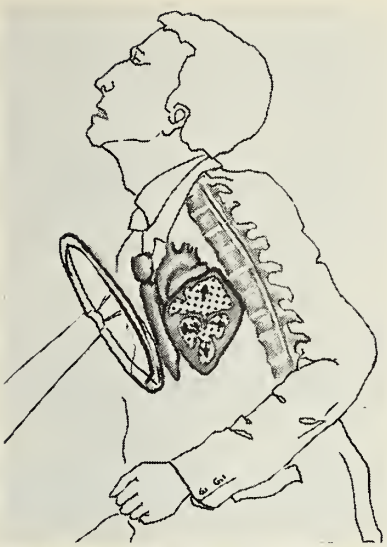


Figure 1. Mechanism of injury in blunt "steering wheel" trauma to the chest with direct cardiac impact.

pericardial sac was distended with bluish discoloration; the pericardial sac was then opened with a gushing of bright red blood estimated at 300 to 400 cc. Prompt increase of blood pressure to 140/80 was noted. Exploration of the heart was immediately carried out, and bright red blood was seen coming from the left atrial appendage. A clamp was placed on the appendage and the tear repaired. The pericardium was closed loosely, followed by closure of the chest. A tracheostomy was performed in the operating room, and the patient was subsequently transferred to the Intensive Care Unit and placed on a volume respirator.

The patient had a relatively stormy postoperative course with supraventricular tachycardia requiring multiple electroconversion and digitalization. Throughout recovery the patient was maintained with intravenous hyperalimentation. Discharged in good condition, the patient has experienced no cardiac or respiratory difficulty in his six postoperative months.

Discussion

Although numerous articles dealing with the incidence, findings, and mechanisms of blunt chest trauma with secondary cardiac rupture have been reviewed, only nine additional cases of successful surgical repair of secondary rupture have been reported.[1-9]

Cardiac rupture has occurred without chest wall deformities or fractured ribs, and has been reported to follow relatively minor trauma. While physical examination may reveal only a bruised chest, more dramatic findings are usually present, including dyspnea, cyanosis, and flail chest. With an intact pericardium the resulting cardiac tamponade may reuslt in decreased blood pressure, feeble or paradoxical pulse, increased central venous pressure, increasingly distant heart sounds, cyanosis, and distention of the veins of the neck. Laceration of the pericardium allows more rapid exsanguination with resulting hemothorax, decreased central venous pressure, feeble pulse, and subsequent hypovolemic shock.

Reviewing 546 autopsies in patients who died from cardiac injury secondary to blunt trauma, Parmley et al.,[9] found that 353 patients died from rupture of the heart. A review of 168 cases by Bright and Beck[3] showed 152 patients with cardiac rupture survived the initial injury. Twenty-one survived from 30 minutes to three days and two survived seven days. Bright and Beck further note that 30 patients survived long enough that surgery could have been considered, and that 29 of the 30 died from cardiac tamponade while only one exsanguinated.

Cardiac rupture must be ruled out in all cases of blunt trauma to the chest. Emergency room X-rays may show hemothorax, enlarged heart shadow (hemopericardium), or a normal chest. Care must be taken to differentiate abnormally increased heart size from the normal enlargement obtained with portable AP X-ray tech-

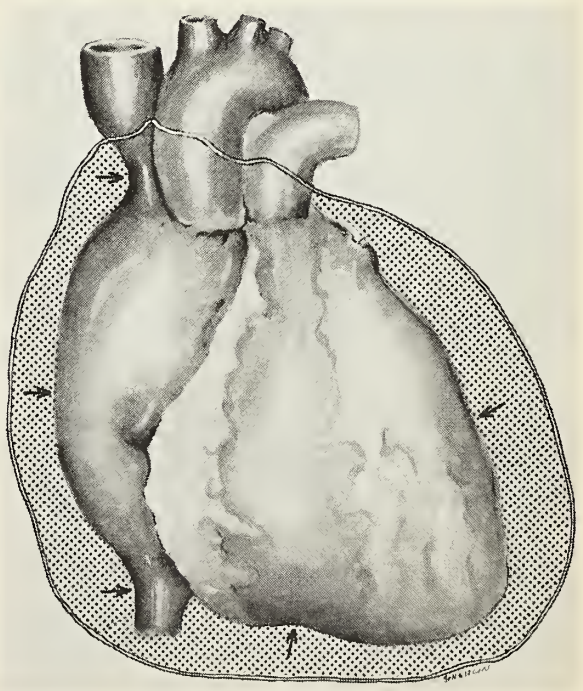


Figure 2. Pathogenesis of cardiac tamponade secondary to ruptured left atrial appendage with intrapericardial blood causing decreased cadiac function and increased central venous pressure.

niques, and once the diagnosis is made, prompt surgical measures should be undertaken. Tube thoracostomy may relieve hemothorax when the pericardium is ruptured; however, when massive bleeding occurs from the chest tube, the tube should be clamped and immediate surgical intervention considered. Pericardiocentesis may alleviate tamponade produced by a small leak that has sealed, or may be of value in temporarily decompressing tamponade while surgical preparation can be made. **It is to be emphasized that cardiac catheterization or other studies to establish the pre-operative diagnosis may actually decrease the chance of survival by delaying corrective surgery.**

The incidence of some degree of cardiac injury in non-penetrating chest trauma, especially that involving high speed auto accidents, is reported to range from 10-75%.[9] With today's more efficient emergency transit systems, it is clear that increased numbers of potentially salvageable cases will reach treatment facilities. Increased awareness of the frequency of cardiac rupture in blunt chest trauma can lead to more prompt diagnosis, early surgical intervention, and increased survival rates. We believe that elevated central venous pressure in a blunt chest trauma patient with shock should immediately arouse suspicion of cardiac tamponade with possible underlying cardiac rupture.

Summary

While cardiac rupture, secondary to blunt chest trauma, is not common, an increase in the incidence of salvageable cases is to be expected as emergency transportation and facilities improve. Prompt diagnosis and treatment are essential if survival rates are to increase.

A case of rupture of the left atrial appendage has recently been treated at Burnham City Hospital Regional Trauma Center, Champaign. The patient underwent successful surgical repair, and after a difficult postoperative course, appears to be the tenth reported case of successful repair of cardiac rupture secondary to blunt chest trauma. ◄

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Hypothermia in the Aged

This survey agrees with many previous reports and the intensive study by Salvosa et al. (1971) in showing a high frequency of low mouth temperatures in elderdly people living at home in the winter. Altogether, 24% of the subjects had a "low" mouth temperature (<35.5°C) and the average for the 72 subjects was only 36.1°C. The average deep body temperature of these elderly people, measured by the urine technique, was also lower (36.4°C) than is normal for younger age groups, but no case of serious hypothermia (<35°C) was found. However, old people with a lower body temperature than younger individuals have less body heat to lose before the deep temperature will reach the hypothermic level and therefore hypothermia can develop more rapidly with exposure to cold.

The "low" mouth temperature group tended to be living in the coldest dwellings with the greatest deficiencies in basic amenities which would help to keep them warm; nevertheless, many of them did not feel they were cold or even shivered and they did not think the heating level was inadequate. This agrees closely with the findings of others and especially Watts (1971). These apparently lower warmth and cold thresholds in some old people, combined with a low environmental temperature in their homes and a reduced safety margin of heat to lose before hypothermia will supervene, would seem to put them especially "at risk." If they become immobilized—for example, falling and injuring themselves—or become further cold exposed for any other reason—for instance, a sudden cold spell and inadequate heating appliances—they are more likely to develop hypothermia. (R. H. Fox, et al., Problem of the Old and the Cold. *British Medical Journal*. (January 6) 1973, pgs. 21-24.)

Pediatric Perplexities Case No. 2

By Ruth Andrea Seeler, M.D.

Pediatric Hematologist, Cook County Hospital & Hektoen Institute/Chicago

"Pediatric Perplexities" will be a series of encounterable, but slightly uncommon, pediatric disorders which require prompt diagnosis and specific management for a good outcome. Initially, the series will be based on patients seen by the author at the Cook County Hospital, Division of Pediatrics. The author welcomes suggestions for types of cases that the readers would like to have presented and discussed. This series will alternate with the maternal death studies.

Patient A, a three-month-old female, was brought to the Cook County Children's Hospital with a two-day history of vomiting and diarrhea. The patient was well until two days prior to admission when the mother noted the onset of a cough which, was rapidly followed by fever and diarrhea with two to three loose stools per day. The child vomited occasionally on the day prior to admission.

The child had a history of a rash at two months of age which was described as red, raised; it faded slowly leaving hyperpigmentated spots. The child also had had a cold for a long time.

Physical examination revealed an active, not particularly dehydrated, child with a temperature of 99°F; pulse 120, respirations 28 per minute, weight under the third percentile. There were numerous flat, 2-4 cms, oval and round hyperpigmented areas over the trunk and extremities. There was a purulent exudate in the nose. Diffuse adenopathy was noted in the neck, axilla, and inguinal areas. The heart and lungs were within normal limits. The abdomen was distended by a liver which extended 4-5 cms below the right costal margin and a spleen which extended 3-4 cms below the left costal margin.

Case B, an eight-week-old female, was admitted to the Cook County Hospital because the mother noticed that the infant was not moving the left arm. Three weeks earlier she had consulted her private physician for this complaint and was referred to another hospital. The infant was seen twice at the other hospital and once at another emergency room for the same

Laboratory Data

A	A	B
Hgb/Hct/Retic	9.4/29/3%	4.6/16/9.2%
WBC	7,000	9,800
Polys/Bands/Lymphs	7/5/74	29/9/59
Mono/Baso/Eos	1/31/-	2/1/-
Platelets	414,000	14,000
IgG	450 mg%	840 mg%
IgA	54 mg%	46 mg%
IgM	155 mg%	230 mg%
Total Protein	5.9 gm%	5.6 gm%
Albumin	3.8 gm%	3.2 gm%
Globulin	2.0 gm%	2.4 gm%
BUN	7 mg%	15 mg%
Other		Direct & Indirect Coomb's Test Negative

complaint. X-rays taken one week prior to admission were read as normal and the diagnosis of possible Erb's palsy was made. The infant continued to become increasingly irritable and the arm more tender. Thus, the mother brought the child to Cook County Hospital.

Physical examination revealed a pale, irritable, infant splinting the right arm. Temperature 99°F, pulse; respirations 36 per minute, weight less than 10 percentile. Positive physical findings were limited to a liver which extended 4 cms below the costal margin and a spleen which extended 2 cms below the costal margin. The abdomen was distended and the umbilical stump appeared to be ulcerated and oozing. The infant would not move the left arm and passive movements were extremely painful. There was a questionable tenderness of the right lower extremities on passive motion. The remainder of the physical examination was within normal limits.

The characteristic symptoms of congenital syphilis are:

- Weight loss or not gaining as expected
- Hepatosplenomegaly
- Jaundice (with elevation of both direct and indirect bilirubin)
- Pseudoparalysis (osteochondritis)
- Rash (frequently mucocutaneous
- Snuffles (a persistant cold)
- Edema (nephrotic syndrome)
- Laboratory:
 - Anemia
 - Thrombocytopenia
 - Leukocytosis ± leukemoid reaction or leukopenia

Our cases are quite classic. Patient A had snuffles, rash, hepatosplenomegaly, leukopenia, and was not gaining as expected. There was only minimum periosteal elevation of the long bones. It is indeed fortunate that a mild intercurrent illness brought this infant to medical attention. Patient B presented with Parrot's pseudoparalysis and was found to have hepatosplenomegaly, severe anemia, thrombocytopenia. X-ray examination revealed marked periostitis. Both infants had a mild hypoalbuminemia and an IgM hyperglobulinemia so characteristic of an in utero infection.

Following therapy all signs and symptoms regressed in the infants. Their parents also were treated appropriately. ◄

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Comments

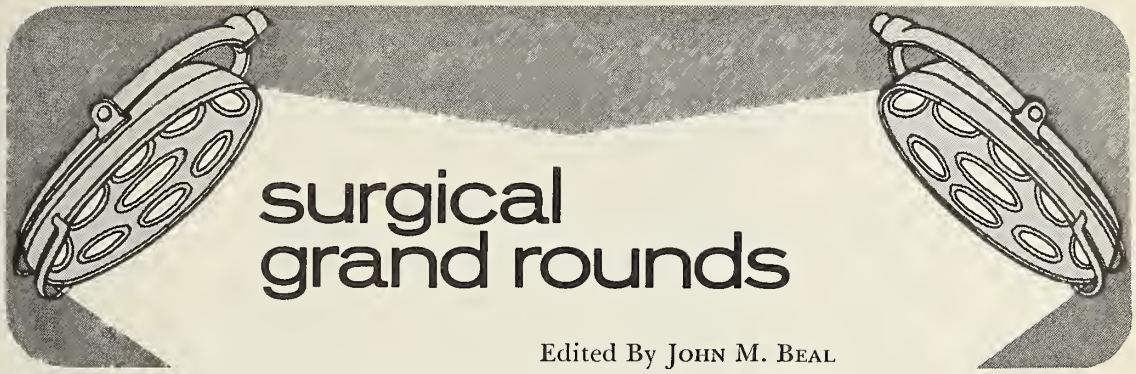
As unlikely as it might appear, both infants have the same disease, namely, congenital lues. Venereal disease has reached epidemic proportions with a younger generation of physicians who have rarely seen a case and thus fail to consider this possibility in a differential diagnosis. The "great imitator" has not changed in its ability to present in multiple manners. Thus, syphilis must be put back into the differential diagnosis of almost all problems in all age groups. ◄



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The Good Old Days

These pre-war post-mortem rooms were presided over by skilled pathologists (the term morbid anatomist was not then widely used), adept at speedy, clean dissection beautifully displaying the naked-eye pathological changes associated with the patient's death. Regularly the "chief" under whose care the patient had perished would attend the necropsy accompanied by his assistants and students, and a lively discussion would ensue on the relationship of symptoms, signs, and treatment to the pathological findings. Sometimes the expected findings were not observed—or the observed findings were not expected. But these things were not cause for rancour, and the discussion would continue until mistakes had been aired and explained and lessons had been learned. ("Decline of the Necropsy," *British Medical Journal* (Saturday, April 24) 1971, pages 181-182.)



Edited By John M. Beal

Bone Cysts in Renal Disease

Surgical Grand Rounds are held weekly on Tuesday at 5:00 P.M. in the Offield Auditorium at Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial and the Veterans Administration Research Hospitals form the basis of the discussions. This case report was part of the Surgical Grand Rounds of February 1, 1972.

Case Report

Dr. George R. Geier: A 51-year-old white woman was admitted to Northwestern Memorial Hospital on January 15, 1972, complaining of pain in the left leg. She was found to have polycystic kidney disease in 1950 and had a strong family history with her mother and 3 of her 7 siblings dying of this disease. For 20 years she had slow but progressive renal failure associated with gradual increase in serum creatinine.

In May, 1970, when she was admitted to Northwestern with a mass in the left breast, it was found to be carcinoma. She was treated by simple mastectomy. The lower axillary nodes also were removed and three of seven nodes contained metastatic carcinoma. Postoperative radiotherapy was administered.

She was asymtomatic until June of 1971 when she was admitted to the hospital complaining of pain in the left knee and hip. This was sharp pain, worse when she tried to walk, but not associated with swelling of the leg or back pain. When examined, she had tenderness just above the left knee without redness or swelling.

The radiologic bone survey was negative; however, a bone scan showed an area of increased uptake in the distal femur which was interpreted as a metastasis from her breast carcinoma. She received X-ray therapy and was again asymptomatic until September. She again complained of pain in the knee and in the right forearm as well. X-rays demonstrated osteoblastic lesions in the distal end of the femur and proximal end of the left tibia and osteolytic lesions in the distal right radius, (Figures 1 and 2). She was readmitted to the hospital and a bone scan revealed increased uptake in the same areas. A biopsy of the left tibia and left radius was obtained.

Dr. Hector Battifora: The bone biopsy shows a remarkable increase in production of new bone. This has resulted in the narrowing of the marrow spaces by newly formed, irregularly shaped bone trabeculae. The remaining marrow space is rather fibrous (Figure 3). This process of osteosclerosis is rarely the result of metastatic breast carcinoma, but occurs with regularity with prostatic carcinoma. Because of the history of breast carcinoma, a careful search for tumor cells was conducted in this biopsy. It was negative.

In addition to exaggerated bone formation, the biopsy shows abundant osteoblasts destroying both old and new trabeculae. The "bony schizophrenia" with destruction and production of bone at the same time accounts for the marked irregularity of the contour of the osseous trabeculae. The picture is reminiscent of that seen in Paget's disease of the bone. One

the time they are ready for hemodialysis and we can often do little to change the hypocalcemia with the twice or thrice weekly dialysis.

Why are they hypocalcemic? Probably because they are absorbing little calcium from the gut secondary to an acquired resistance to the action of vitamin D. As you will recall, vitamin D is important in the absorption of calcium, and patients with a creatinine clearance of less than 10 ml/min have an altered metabolism of this vitamin with a decrease in the biologically important components. At this point, histologically, the patient may present with osteomalacia, similar to that seen in rickets of vitamin D insufficiency, with very soft bones, but clinically few symptoms. With prolonged hypocalcemia, the parathyroid gland is stimulated to increase it's secretion of parathormone. This continues unabated during the term of the patient's renal insufficiency often causing Osteitis Fibroma Cystica. The etiology of the osteosclerosis that was presented here is unknown. There is a local increase in mineralization as well as increased bone formation.

With respect to this patient and in particular the need for parathyroidectomy, it has been found by experience in centers similar to ours, that once these patients have evidence of symptomatic bone disease, there is little regression of the process which often leads to large cystic lesions and fracture unless subtotal parathyroidectomy is done. The other problem, even more lethal, is the occurrence of the metastatic calcification. The increased parathormone output will tend to normalize the serum calcium as it starts to reabsorb both matrix and mineral in the bone. This combined with an elevated serum phosphorus common to uremics leads again to an increased calcium phosphorus product and metastatic calcification. Occasionally, the product remains elevated in spite of the use of aluminum containing antacid compounds designed to decrease phosphorus absorption from the gut. Parathyroidectomy is then considered.

The reasons for parathyroidectomy vary with each center, but two or three of the following are generally accepted. Evidence of progressive cystic bone disease, symptomatic bone disease such as the localized pain this patient presented, and X-ray evidence of metastatic calcification. Many centers are now doing ¾ or ⅞ subtotal parathyroidectomy in those patients.

The question of the need for parathyroidectomy in the patient with renal osteodystrophy soon to receive a renal allograft often occurs. This brings up the point of a so called tertiary hyperparathyroidism. In other words, does this gland, if it is stimulated long enough by hypocalcemia, become autonomous and therefore refractive to the normalization of calcium and renal function once the transplant is done?

I think the feeling among nephrologists is that there is probably no such thing as tertiary hyperparathyroidism. In other words, these glands will involute once calcium and renal function his been normalized. But the hooker is that they may take several months or even a year before they begin to involute. During that period of time we run the risk of further metastatic calcification or, even with the high calciums after transplant, of having renal thiolysis or necrocalcinosis which has been reported in some of the transplants from the Boston group. Even some of the patients who are going for transplants, in certain centers, are being parathyroidectomized, if they have these signs of bone disease or an increase in calcium phosphorus product with metastatic calcification. There is sometimes an extra bonus in the patients, the decrease in generalized peritonitis. For those unaware of the peritonitis associated with renal disease, it can become a morbid problem for the patient and hard for the physician to control; in some cases a parathyroidectomy has been done for intractible peritonitis, with good results in several weeks to months following this procedure. This patient complained, too, symptomatically of peritonitis.

Dr. James Hines: The internists are to be congratulated of the accurate diagnosis in this case. The patient, a year and a half ago, developed carcinoma of the breast with some positive nodes and if you see a bone lesion in this patient you are apt to diagnose metastatic disease of the breast and not pursue it. A biopsy of the bone was taken and Dr. Battifora has presented it here. This patient had cystic kidney disease and was not a candidate for resection of her kidneys with transplant as you are dealing with a patient who has carcinoma of the breast.

The bone disease was proven to be due to the parathyroid disease secondary to renal disease. In spite of the fact she had several diseases and a lot of problems, we must pursue these cases and make intelligent and thoughtful plans for them and carry them out.



Figure 1. Roentgenogram of left tibia demonstrated osteoblastic lesion.



Figure 2. Osteolytic lesion with detected in distal portion of the right radius.

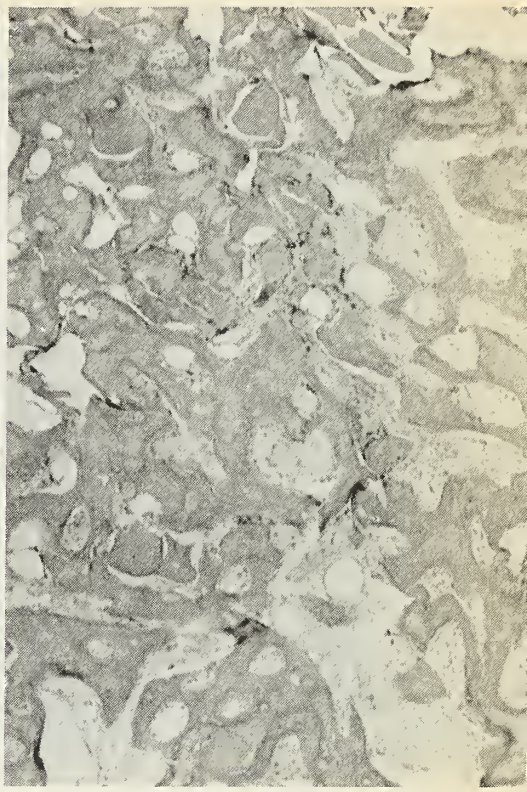


Figure 3. Biopsy of right radius demonstrated irregularly-shaped trabeculae, fibrous marrow and absence of tumor cells.

more feature of interest is the presence of thick rims of apparently uncalcified osteoid around the new bone. This defect of mineralization suggests a metabolic disturbance leading to a superimposed osteomalcic process.

Dr. George R. Geier: A diagnosis of renal osteodystrophy was made. Pertinent laboratory values are of interest: serum calcium was 10.1 mgm% (normal), but serum phosphorus levels ranged from 5.9 to 8.0 mgm%, serum creatinine was 9.2 mgm/100ml (normal 0.2-0.8 mgm%). She was taken to the operating room on January 20, 1972, where 3½ of 4 of her parathyroids were removed. She recovered uneventfully without clinical signs of hypocalcemia although her serum calcium fell as low as 7.6 and her phosphorus had remained elevated.

Dr. Hector Battifora: The parathyroids were somewhat enlarged, one of them was about twice the normal size. Histologically, the predominant cell is the water clear cell and the glands have scant amount of adipose tissue. These are all findings of hyperplasia of the parathyroids.

Dr. Donald Froom: I was asked to explain why the Nephrology section referred this patient for subtotal parathyroidectomy for treatment of her renal osteodystrophy. The incidence of symptomatic bone disease in the patient with renal insufficiency with respect to localized bone pain or fracture is probably less than 10%. However, bone biopsy analysis of these patients at the time they are admitted for hemodialysis reveals an incidence of some type of bone lesion in approximately 80 to 90%. The types of lesions seen include Osteomalacia or demineralization of bone, Osteitis Fibroma Cystica or the lesion associated with hyperparathyroidism, and finally the lesion already discussed, Osteosclerosis.

There is another problem associated with an elevated calcium phosphorus product in these patients and that is metastatic calcification. Several case reports have appeared in the nephrology literature of metastatic calcification in the media of arterioles with occasional ischemic necrosis of extremities, particularly fingers and toes, calcification in the conjunctivae of the eyes, and even calcification in the cardiac conducting system occasionally accounting for sudden death.

The etiologic factors are many and I won't go into all of them except to discuss the role of hypocalcemia. About 90% of the patients with chronic renal insufficiency are hypocalcemic by

(Continued on page 287)

Hemospermia

By Leander W. Riba, M.D., F.A.C.S. and Salman Kazmi, M.D./Chicago

Hemospermia denotes blood of varying degrees in the ejaculate semen. This affliction is uncommon in males and usually asymptomatic. The blood, in the semen, may be right red, dark or black, sometimes called "prune juice." In a few instances the blood may be of short duration. However, in the majority of cases, it may manifest itself for years.

The cause of hemospermia may be difficult to determine and localize. The most common associated lesions are infection of the prostate and/or seminal vesicles. In older patients, bladder neck obstruction, adenoma of the prostate and, rarely, a polyp or malignant tumor of the seminal vesicles have been noted. In the younger male, anomalies, gonorrhea, urethral strictures, masturbation, verumontantitis, and sexual excesses may become the precipitating factors. Occasionally, a blood dyscrasia is accompanied by hemospermia. A careful history may help to pinpoint the etiology.

The following are three case histories that are of interest in this field. The mental reactions of these males are acute and may cause considerable anxiety and frustration, serious enough, to disturb the home tranquility and sex life. The average women does not enjoy sexular relations with a hemospermic male.

Case #1

G. T., age 59, two star general, was seen in the service in 1944. He complained of what he described as prune juice ejaculations for three years. Treatments had been unsuccessful. He was hospitalized and given a careful urologic survey. The findings revealed a small adenoma and palpable seminal vesicles. Bushnell General Hospital in Brigham City, Utah, was the second Army Hospital to set up a penicillin center. We had to contact the Surgeon General's office to receive permission to instill 20,000 units of penicillin into each seminal vesicle through vasotomy incisions. He made an excellent recovery and was pleased about the treatment and recovery.

Case #2

P. C., age 68, was seen in the office on May 18th, 1964, complaining of bloody ejaculate for many months. Examination revealed a moderately enlarged, infected prostate and diabetes mellitus. Oral achromycin promptly cleared his hemospermia but blood recurred after discontinuance of the treatment. He was hospitalized, X-rayed, cystoscoped and except for a moderately enlarged prostate the findings were unremarkable. Bilateral vasotomies and seminal vesiculograms (Fig. 1) revealed dilated seminal vesicles. One hundred milligrams of achromycin were instilled into each seminal vesicle. He has remained well for eight years.



Figure 1. Case #2—Bilateral dilatation of both seminal vesicles due to infection.

Case #3

G. S., age 30, was first examined in the office

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on September 14th, 1971, complaining of blood in the ejaculatory fluid for three years. Married for one year, this did not alter his complaint. He had normal ejaculations prior to 1968. No other contributory factors were elicited. Physical examination was normal, except that the prostate and seminal vesicles revealed w.b.c.'s and r.b.c.'s in the seminal fluid. Palpation revealed indurated seminal vesicles. The urine was normal. He was given oral Tetrex and the prostatitis cleared but the hemospermia persisted.

He was admitted to the hospital on December 9th, 1971, for X-rays, cystoscopic and urethroscopic examination. Pre-admission I.V.P.'s made November, 1971, were normal. The physical examination was negative. The urine culture was sterile. Urethroscopic examination revealed mild posterior urethral granulations which were treated. No other abnormalities were noted. He was discharged on antibiotics but the hemospermia persisted. A semen specimen in March, 1972, revealed marked reduction in the sperm count with very little motility. There was gross blood and pus cells in the 1.7 c.c. semen specimen. Re-hospitalization was advised and bilateral vasotomies and seminal vesiculograms were carried out on April 27th, 1972. The X-rays revealed a right hydro-seminal vesiculitis, moderately severe (Fig. 2). There were 300mgm of achromycin left in the right seminal vesicle and 100mgm in the left. Patient was discharged the following day on antibiotics. The culture of the seminal fluid revealed betahemoyltic streptococcus and a few staphylococcus epidermides.

He has been cleared but must be followed for recurrence. If so, ejaculatory duct catheterization and re-instillation of an antibiotic will be carried out. It is remotely possible that a seminal vesiculectomy would be indicated.

Treatment

The corrective measures are suggested by the urological examinations. Oral antibiotics, in the presence of infection, are indicated. When antibiotics fail, a complete investigation, including I.V.P.'s, cystoscopy, urethroscopy and seminal vesiculograms, is necessary. The instillation of an appropriate antibiotic directly into the seminal vesicles is effective in most instances. The anatomical blood supply arrangement tends to circumvent complete erradication of the seminal vesiculitis. Catheterization of the ejaculatory ducts, when possible, will allow culturing of the seminal fluid and instillation of an antibiotic. Passage of the catheter may aid in subsequent expulsion of the seminal fluid. In rare instances,

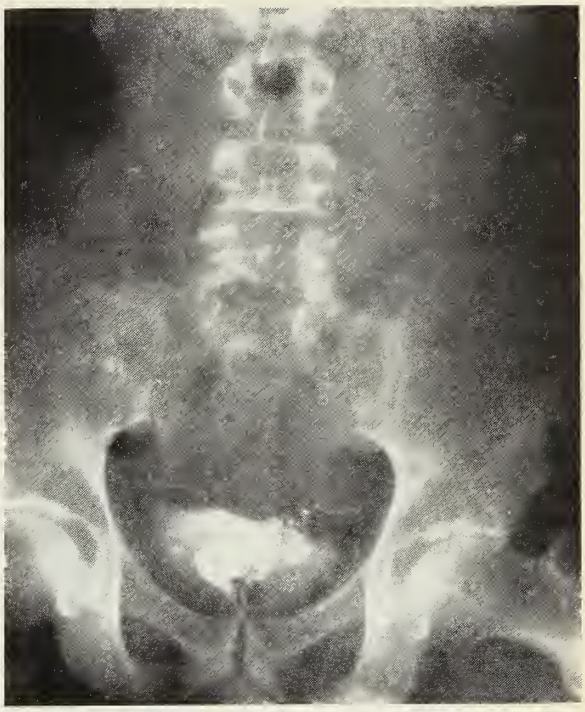


Figure 2. Case #3—Marked dilatation of right seminal vesicle due to streptococcus infection, cleared by instillation of 300 mgms of achromycin. Recurrence is anticipated.

such as tumor formation, a seminal vesiculectomy is indicated.

Discussion

Hemospermia is an affliction which is very disurbing to both the male and female. Every effort should be made for an early diagnosis and treatment. Patients with hemospermia should be counselled, intimately, to allay the serious psychosomatic reactions which follow the discovery of blood in the semen ejaculate. A review of the literature reveals a very few articles. A discussion by Talarico in 1970[1], seems excellent. He emphasizes the search for genito-urinary tuberculosis. In our experience this complication has not been noted. Sterile cultures in the presence of infections would suggest tuberculosis.

Conclusions

This is an uncommon, serious affliction. Every effort should be made to pinpoint the diagnosis for adequate treatment. The demonstration of a hydro-seminal vesiculitis (Fig. 2) is most interesting. A more positive approach to treatments are available after the urinary and seminal tracts have been studied and visualized. ◄

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Medical Applications of RIQS. A Computerized Information Retrieval System

By Fred Levit, M.D. and Robert Chalice, M.S./Chicago

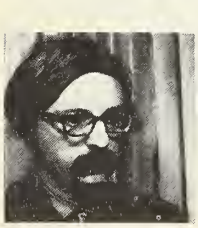
RIQS is an information and retrieval system which is especially suitable for medical use. The user can do complex searches of files of information easily and without the need for someone else to do the programming. The system is able to search for words, phrases, dates, or numerical values on the basis of logical criteria such as "greater than," "less than," and "not equalt to." The system is simple to use, which enables the physician himself to perform the searches.

The Remote Information Query System (RIQS) was developed at Northwestern University's Vogelback Computing Center to provide a means of storing and searching large files of information quickly and economically. A major emphasis during the design of RIQS was simplicity and ease of use. It was felt that the people who needed the system most would be in fields other than computer sciences, and therefore using the system should require a minimum of training. As finally constructed, RIQS turns out to be very simple to use and remarkably well adapted to many of the information storage and retrieval needs in the field of medicine.

RIQS is designed for creating, searching, and updating files of information. The files are stored in the computer either on disk memory units or on magnetic tape. A file is made up of "records," each of which contains "items" of information. In the case of a file of skin biopsies, each record is one biopsy report. Each record is made up of items such as biopsy serial number, patient's name, doctor's name, clinical diagnosis, histologic description, date of biopsy, and so on. These items may be of various types. The biopsy serial number is an integer, while the date of the biopsy is a date, and the histologic description is a paragraph of English text. Exact information contained in the biopsy resport is punched verbatim on cards for storage as a disk file. The disk file contains exactly the same information as the original collection of biopsy reports. A disk file of about 5,000 biopsy reports can be searched by the RIQS program in about ten seconds, whereas a comparable manual search would take about 20 hours. Also, the file can be transferred to one nine inch reel of magnetic tape for compact permanent storage.

After a file has been created on the disk storage unit, it can be searched in a variety of ways. In the case of the skin biopsy file, for example, a simple interrogation would be to find and print the record having a given biopsy serial number. A more complex interrogation would be to find and print out the biopsy serial numbers of all patients between the ages of 18 months and 23 years whose biopsy was done in the year 1969, and whose clinical diagnosis was basal cell carcinoma while the histologic diagnosis was not basal cell carcinoma.

Almost any search that can be verbalized can be performed. A numeric item can be searched for specified values, for values within a specified range of values, or for values greater than or less than a specified value. An item containing a date can also be searched for a specific date, a range of dates, or dates before or after a given date. English language text can be searched for single words or phrases. Text is searched so rapidly by the RIQS processor that it is not necessary to use codes for diagnoses. Instead, the English language words, and any synonyms are used in performing the search.



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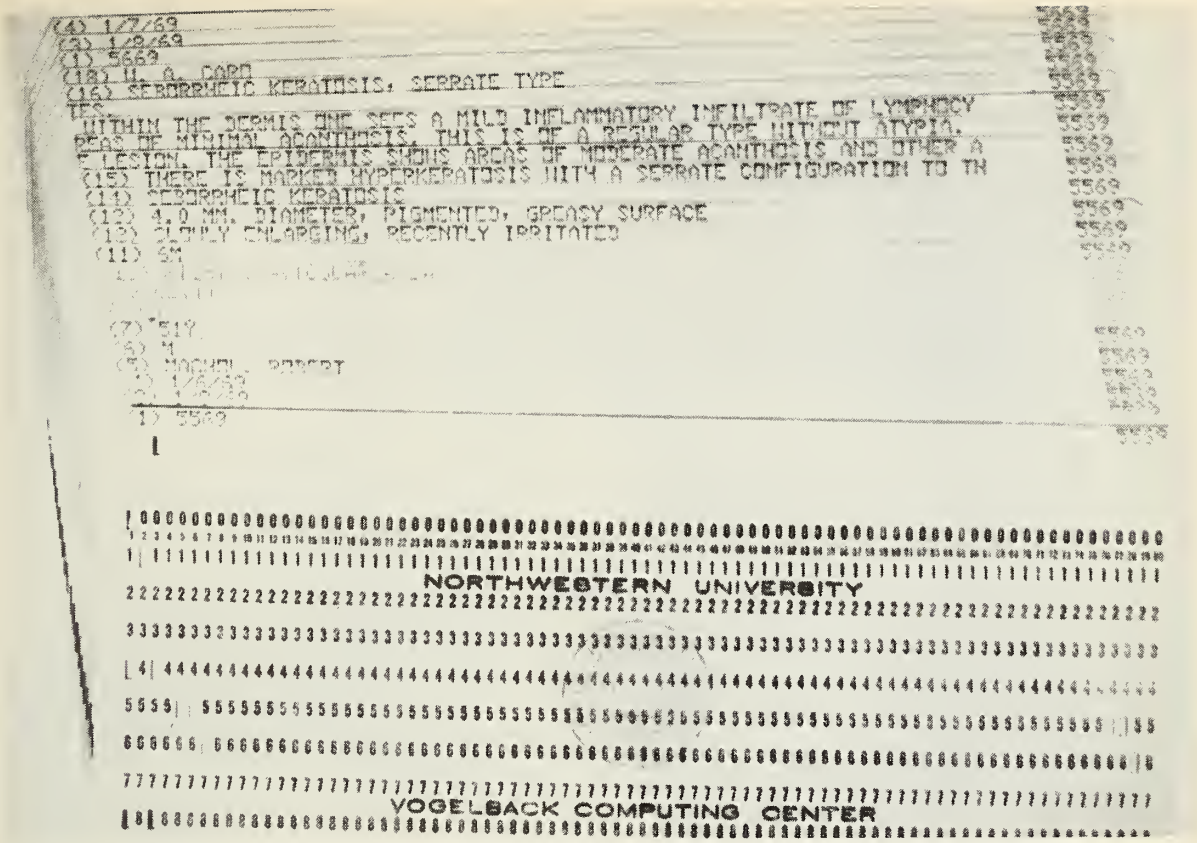


Figure 1. Cards punched with data of biopsy no. 5569 and part of biopsy no. 5669.

Creating a File

The use of RIQS is probably best described by an example. In the case of the storage of skin biopsies, the first step is to take the biopsy report form and assign an item number to each item on the report form. Thus, *Biopsy Number* is item 1, *Clinic Number* is item 2, *Name* is item 5, *Histopath Description* is item 15, and so on. The item number enclosed in parentheses will be used throughout RIQS to reference the data of an item. The possible content of some items may be restricted. *Biopsy Number* (1) should contain only an integer, for example, while *Age* (7) must contain a number and a letter (e.g. 24Y for 24 years, 18M for 18 months). Any input data not satisfying the restrictions declared will be rejected during the input data process with an appropriate diagnostic message being printed for the user.

The complete program for creating the file is seen in Table 1. Note that the bulk of the program is simply a list of the item numbers and names. The statement *Create Biopsy File* assigns the name "*Biopsy*" to the file being created. The four statements under *Data Restrictions* establish the requirements that item 1 must be an integer, and that items 7 and 11 are decimal numbers with the unit equivalences as shown. This informs the computer that in a search of items 7 or 11, 24 hours equals one day, 7 days equal 1 week, etc. Similarly, the statement *Date* (3) (4) establishes the requirement that the content of items 3 and 4 must be a date.

Input Data is the last statement in the program. What follows this statement is the actual data, keypunched verbatim from the biopsy report form. It must be emphasized that the listing in Table 1 is actually the *entire program needed* to create the file. This program is used only once, at the time the file is created and the first data entered. The disk file which is created and saved may later be searched repeatedly as the user's needs require.

Table 1 shows the way that the data is punched. The item number, in parentheses, is immediately followed by the content of that item. The content of any item can run onto additional cards or several items may follow each other on a single card. If an item has no content it may simply be omitted from the input. No formatting of input is required, rather input is punched free field with an item number being followed simply by the information it is to contain.

At the time the file is created, or at the time data is added to an already existing file, the

RIQS processor prints out a copy of the accepted data as well as extensive diagnostic statements indicating the reasons for any data being rejected. A non-integer value for a biopsy number, for example, would result in the rejection of that particular value.

Searching the File

Searches may be done either online by keying them into a teletype or as a batch by punching them on cards. The batch mode is faster and is able to perform all the searches in a single pass through the file. The online mode permits searching the file from the location where the results are needed, and provides almost immediate response to the user. Statements in either method are almost identical and the examples given here are taken from the teletype.

With the teletype on and connected by telephone to the computer, several statements are needed to attain access to the RIQS processor and the file to be searched. Once the RIQS processor and the user's data file have been accessed, searching can begin. Still using our biopsy file to provide an example, the RIQS statement needed to search the file and print the entire record of biopsy number 23469 is:

If (1) *EQ 23469 then Print Report; End*

This statement tells the computer to read item 1 of each record in the file, and that if any item number 1 in the file equals (i.e., *EQ*) the number 23469, then that record is to be printed. After the statement is entered, the RIQS processor will perform the search and print the following:

Searching initiated
Number of reports generated to print file = 1
Do you want the reports printed?

If the user types back *yes* then the report is automatically printed. Figure 2 shows such a report.

Let us assume that we wish to know the serial number, histologic description, and histopathologic diagnosis of every biopsy in our file in which a lymphocytic infiltrate was mentioned in the histopathologic description. We wish therefore to search the HISTOPATH DESCRIPTION (item 15) for the words, "lymphocyte", "lymphocytes", or "lymphocytic". We wish to have printed the *Biopsy No.* and *Histopath Description* (item 1 and 15). The *entire* search command would be as follows:

If (15) *EQ* (*'lymphocyte'* or *'lymphocytic'* or *'lymphocytes'*) *then print* (1), (15); *end*

The computer will respond as in the previous example, giving the number of reports generated and then on request print items 1 and 15 from each record which contained the searched for words in item 15.

```
SEARCHING INITIATED


NØ. ØF REPØRTS GENERATED TØ  PRINT  FILE =    0
NØ. ØF REPØRTS GENERATED TØ DISPLAY FILE =    1

DØ YØU WANT THE DISPLAY REPØRTS LISTED
? YES


 RECØRD NUMBER  55

    1.  BIØPSY NØ.
          5569
    3.  DATE RECEIVED
          1/8/69
    4.  BIØPSY DATE
          1/6/69
    5.  NAME
          MACHØL.  RØBERT
    6.  SEX
          M
    7.  AGE
          51Y
    8.  RACE
          W
    9.  DØCTØR
          LEVIT
   10.  BIØPSY SITE
          RIGHT CLAVICULAR AREA
   11.  DURATIØN ØF LESIØN
          6M
   12.  CLINICAL HISTØRY
          SLØWLY ENLARGING, RECENTLY IRRITATED
   13.  CLINICAL DESCRIPTIØN
          4.0 MM.  DIAMETER, PIGMENTED, GREASY SURFACE
   14.  CLINICAL DIAGNØSIS
          SEBØRRHEIC KERATØSIS
   15.  HISTØPATH DESCRIPTIØN
          THERE IS MARKED HYPERKERATØSIS WITH A SERRATE CØNFIGURATIØN
          TØ THE LESIØN.  THE EPIDERMIS SHØWS AREAS ØF MØDERATE
          ACANTHØSIS AND ØTHER AREAS ØF MINIMAL ACANTHØSIS.  THIS IS
          ØF A REGULAR TYPE WITHØUT ATYPIA.  WITHIN THE DERMIS ØNE
          SEES A MILD INFLAMMATØRY INFILTRATE ØF LYMPHØCYTES.
   16.  HISTØPATH DIAGNØSIS
          SEBØRRHEIC KERATØSIS, SERRATE TYPE
   18.  HISTØPATHØLØGIST
          W.  A.  CARØ

*  *  *  *  *

ENTER SEARCH COMMAND ØR TYPE HALT
```

Figure 2. A biopsy report as printed by the teletype.

Searches can be much more complex than these examples, and may contain numerous *and, or EQ, GT* (for "greater than"), and *LT* (for "less than") relations embedded within parentheses to any level. The RIQS processor also has a built in indexing capability, and such things as keyword in context indexes are readily prepared by the system on request.

Additional Applications

There are many other areas in medicine where computer storage of files of information would be useful. Information such as is contained in a tumor registry, in diagnostic radiology reports, and in serologic reports for a syphilis clinic could all be filed easily using RIQS. A file of surgical pathology reports now being established for two of the hospitals at the Northwestern University Medical Center uses RIQS. In this file each record contains items which include an accession number, patient identification information, clinical diagnosis, and a gross and microscopic description as well as a histologic diag-

Table 1

The Entire Program Needed to Create A File of Skin Biopsies

RIQS Create Biopsy File
Record Definition Items

(1) *Biopsy No.*
(2) *Clinic No.*
(3) *Date Received*
(4) *Biopsy Date*
(5) *Name*
(6) *Sex*
(7) *Age*
(8) *Race*
(9) *Doctor*
(10) *Biopsy Date*
(11) *Duration of Lesion*
(12) *Clinical History*
(13) *Clinical Description*
(14) *Clinical Diagnosis*
(15) *Histopath Description*
(16) *Histopath Diagnosis*
(17) *Comments*
(18) *Histopathologist*
(19) *Special Stains*
(20) *Recuts*
(21) *Teaching Slide*
(22) *Previous Biopsy No.*

Data Restrictions
Types
Integer (1)
Decimal with Units 1Y=12M, 1M=30D, 1W=7D, 1D=24M (7) (11)
Date (3) (4)
Input Data in Columns 1 Thru 70

nosis. The file can be searched from a teletype when little printout is anticipated. When searches are done which require considerable printout, the output may be diverted to high speed printers at the central installation, or the search may be performed in batch mode. For example, the preparation of annual lists of accession numbers by diagnosis results in too much output to be printed on the relatively slow teletype.

RIQS is best suited for handling medium size records. It would be impractical to use RIQS to store records of the size of an average hospital chart. However, brief clinical records, or chart summaries, can be adapted easily to computer storage by RIQS. A RIQS file of ten thousand clinical summaries is being used at Children's Memorial Hospital in Chicago to perform routine searches which would be both too time consuming and too costly to perform by hand.

Availability

The RIQS processor is a program written mostly in Fortran. It is written for Control Data 6000 series computers but adaptations to other computers is being considered. A RIQS user's manual containing details on capabilities and requirements has been published and is available from Northwestern University's Vogelback Computing Center.[1]

Estimated Costs and Benefits of Using RIQS

The greatest cost of using RIQS lies in data preparation. An average biopsy report is keypunched in about 12 minutes. Direct generation of machine readable input during the typing of the biopsy report has been considered to eliminate keypunching operations. The cost of accepting the records and storing them as a disk file is about 8¢ per record. For skin biopsies the total cost is about 75¢ per record for both keypunching and acceptance by the program. This is a one time cost since the file is created only once.

The search phase of RIQS was designed to be as fast as possible since it is anticipated that this phase will be the most often used. A search of a file of 5,000 medium sized records can be performed in about one minute of real time at a cost of about $2.50. To perform a comparable search by hand might require as much as 15 to 20 hours of clerical staff time. Some of the complicated searches which can be performed by the system, such as those involving the searching of free English text, would not even be considered for performance manually.

In addition to the speed and economy of searching, and the ease of use of the system, the data base can be maintained in a very compact form on magnetic tapes. This eliminates the need for accessing the original bulky card input, or the numerous original biopsy report forms. ◄

References

1. Chalice, R., Dillaman, D., and Borman, L.: "A RIQS User's Manual." Evanston, N. U. Vogelback Computing Center, 1970.



medical legal review

Is Every Accidental Injury Compensable?

By Joseph T. Lavorci/Chicago

Is every employee who sustains an accidental, work-related injury entitled to compensation under the Illinois Workmen's Compensation Act? Mr. Lavorci points out that the facts and circumstances in each case determine whether the employee is entitled to compensation for his injury.

Every accidental injury is not compensable under the Workmen's Compensation Act of Illinois.[1] To come within the purview of the Act, an accidental injury must "arise out of" and "in the course of" the employment. Both elements must be present. An accident can "arise out of" and "in the course of" employment when it occurs within the period of employment at a place where the employee may reasonably be required to be while in the discharge of his duties or while engaged in some activity reasonably incidental to his work.[2] In other words, the term "arising out of" deals with the origin or cause of the accident, while the term "in the course of" refers to the time, place and circumstances under which the accident takes place.[3]

The problems in this area include the rights of the employee and the liability of the employer for accidental injuries occurring while the employee is on his way to or from his job, before or after working hours, violating the employer's instructions, upon being exposed to the elements or acts of God, while performing emergency acts or acts thought to be for the employer's benefit, as a result of horseplay, lunchroom activities, or assaults, while participating in the employer's recreational activities, while performing acts for the personal comfort of the employee, and many others.

JOSEPH T. LAVORCI, a Chicago attorney, is president of the Chicago Society of Medical Jurisprudence and past president of the Trial Lawyers Club of Chicago.

Traveling to or from the Job

As a general rule, coverage for the employee, whose duties are confined to the employer's premises, does not begin until he arrives and terminates when he leaves the premises, and is not entitled to recover for injuries sustained in an accident while traveling to or from his job. On the other hand, if the employee's duties require him to travel from place to place, as in the case of a traveling salesman, then he is deemed to be in the course of his employment from the time he leaves home until he returns. However, even where the employee's duties are limited to the employer's premises, if, in traveling to or from his job, he is exposed to a special risk incidental to the employment or he is performing an act, incidental or otherwise, for the employer, the accident may be deemed to have arisen out of and in the course of the employment.[4]

On or Off the Employers Premises

When the employee reaches the employer's premises, even though he has not begun the performance of his duties, the general rule with reference to traveling to or from the job is not

applicable.

If the employee is injured on the premises of the employer while traveling to or from his job, within a reasonable time before or after his regular working time, such accident is deemed to have arisen out of and in the course of employment.

Where the sole or customary means of entry to or egress from the employer's premises is crossing a hazardous area, such as railroad tracks, and the employee is injured as a result of such hazard even though he had not reached the employer's premises, the hazard is deemed to stem from the employment, and an accidental injury so incurred was held to arise out of and in the course of employment.[5]

Accidents Resulting from the Elements and Acts of God

Accidents resulting from exposure to the elements or acts of God are held not compensable, even though they may occur while the employee is in the process of discharging his duties and at a place where his employment reasonably requires him to be. However, if the nature of the employment exposes the employee to a greater risk of such injury, or the risk exists to a greater degree, then the accident may be attributable to the employment.[6]

Violation of Employer's Instructions

The rule applicable in this category is as follows: If the instruction deals with the manner in which the task is to be performed and the employee violates the instruction by performing the task differently, the violation constitutes an act of negligence and does not remove the employer from the scope of his employee. However, if the instruction deals with a restriction of the scope of duties to be performed by the employee, and in violation of such instruction, he deviates from or transgresses the scope of his employment by performing a function which he was not hired to do and which he was in fact forbidden to do, then the violation removes him from the scope of his employment.[7]

Increasing Hazard of Employment

While the negligence of an employee does not constitute a defense to a compensation claim, it has long been the established rule in Illinois that when the employee places himself in a dangerous place where his employment does not necessarily carry him, and he incurs a danger of his own choosing outside the reasonable requirements of his employment, the risk is not one incidental to or arising out of the course of his employment.[8]

Assaults

It is the general rule that an injury sustained by an employee in a fight with another employee can only be considered to arise out of the employment if the quarrel resulting in the assault relates to the employer's work in which the participants were engaged. In order to entitle the claimant to recover, he must further show that he was not the aggressor.[9]

Horseplay

It is the general rule that an accidental injury from horseplay may be deemed to arise out of and in the course of employment if it occurs under circumstances which would otherwise render the case compensable and if the injured employee does not participate in the horseplay.[10]

Accidents During Lunch Periods

The general rule may be stated that the act of procuring lunch is reasonably incidental to the performance of work, and an injury sustained while going to or from lunch on the employer's premises arises out of and in the course of the employment. However, where the lunch period is not subject to the employer's control or restriction, and the employees are free to go wherever they desire, an injury sustained while off the employer's premises does not arise out of the employment.[11]

Acts of Personal Comfort

As a general rule, an employee may do things which are necessary to his own health and comfort, even though they are personal, and such acts are considered incidental to his employment. An accident occurring while he is performing such an act of personal comfort arises out of and in the course of his employment.[12]

Hazards to the Public at Large

Even though an accident occurs during the employee's working hours and at a place to which he is brought by virtue of his employment, the accident does not arise out of his employment if the causative factor of the accident has its origin entirely outside of his employment, and the employee is exposed to a degree of risk no greater than the public at large in the community.[13]

Recreational Activities

There has been a trend through the years on the part of employers to sponsor various athletic and social activities among their employees. The question as to whether such activity may be considered to fall within the sphere of employment so as to render an accident resulting therefrom as one arising out of the employment was decided by the Illinois Supreme Court for the first time in the *Jewel Tea Co. v. Lejman* case,[14] where it held that the injury sustained by an employee while he was playing in an intra-company baseball league after working hours was compensable on the theory that such participation resulted in improved employer-employee relations.

Voluntary Acts and Deviation from the Scope of Employment

As a general rule, voluntary acts would not fall within the scope of employment, and an accident arising therefrom would not arise out of it. However, if the employer permits or consents to the performance of the act, or if the act is one for the benefit of the employee under conditions of emergency, the horizon of the employment may extend to include such acts within its scope.[15]

Conclusion

It is the writer's objective that when the reader has reviewed this article (1) he will know that every accidental injury is not compensable under the Illinois Workmen's Compensation Act; (2) he will have knowledge of the fundamental rules and case law that he can apply to determine the compensability of an accidental injury; (3) he will know that compensability depends on the facts and circumstances in each case; (4) he will know that under the Illinois Workmen's Compensation Act, the employer is not an insurer of the employee's safety during the period of employment; and (5) he will know that there must be a causal connection between the condition and environment of employment and the injury. ◄

References

1. Ill. Rev. Stats., Ch. 48, Secs. 138.1-138.28 (1971).
2. *Chmelik v. Vana,* 201 N. E. 2d 434 (1964). An injury accidentally received within a reasonable time before or after work on a parking lot maintained by an employer for use of its employees was received in the course of and arising out of employment.
3. *McField v. Lincoln Hotel,* 182 N. E. 2d 905 (1962). An employee, who was injured as he left his employer's premises by means of a required doorway at a reasonable time after actual work terminated, suffered injuries arising out of and in the course of employment within the meaning of the Act.
4. *Northwestern Steel & Wire Co. v. Industrial Commission of Illinois,* 232 N. E. 2d 293 (1967). Whether a particular injury received by an employee while traveling to or from work arose out of and in the course of his employment is a question of fact depending on the circumstances of the case.

 Urban v. Industrial Commission of Illinois, 214 N. E. 2d 737 (1966). The court held that ordinarily, accidents occurring while an employee is traveling to or from his place of employment do not arise out of and in the course of employment. An exception to the general rule involves a traveling salesman whose duties require him to travel from place to place.

 Thomas Reed & Son v. Industrial Commission of Illinois, 224 N. E. 2d 790 (1967). As a general rule, accidents that occur while an employee is traveling to or from his job do not arise out of and in the course of his employment. However, this is not true where the employee's trip is determined by the demands of his employment.
5. *McField V. Lincoln Hotel,* cited at footnote 3. There is an exception to the general rule that injuries suffered while an employee is traveling to or from work do not arise out of or in the course of employment. The court held that where an accident occurs on the employer's premises or adjacent premises, the employee is, by virtue of the employment, particularly subject to such danger.

 Spees v. Stapleton, 250 N. E. 2d 181 (1969). An employee brought a common law action against his fellow employee for injuries sustained when he attempted to extricate the fellow employee's automobile from snow on the employer's parking lot one-half hour before starting time. The court held that such injury did not arise out of or in the course of employment and was not incidental to employment.

 Hiram Walker & Sons v. Industrial Commission of Illinois, 244 N. E. 2d 179 (1968). An employer is responsible for the maintenance and control of a parking lot provided for use of his employees, and an injury sustained by an employee in the lot within a reasonable time before or after work arises out of and in the course of his employment.
6. *American Freight Forwarding Corp. v. Industrial Commission of Illinois,* 201 N. E. 2d 399 (1964). The court held that where the employee developed frostbite even though he took extraordinary precautions to protect himself from the cold while exposed to temperatures that averaged 6 degrees below zero, he was exposed to a risk greater than the risk to which the public in the vicinity were subjected. Therefore, his injuries were compensable.
7. *Sauer, Admr. of the Estate of Darrell E. McKinney v. Iskowich, Admr. of the Estate of Grandell J. Ring,* 224 N. E. 2d 21 (1967). A finance company employee took an auto which had been repossessed by his employer and left it at a gas station at 6 p.m. for the employer, and his job was then completed. The employee picked up the auto at 7 p.m. and he was seen in a tavern at 10 p.m. Later, at 12:50 a.m., while intoxicated and driving at a high rate of speed in the direction of the gas station, he was involved in a fatal automobile accident. The court held that the employee was not acting in scope of employment.

8. *Field Enterprises v. Industrial Commission of Illinois,* 226 N. E. 2d 867 (1967). To recover under the Act, the employee's death or injury must be the result of a risk to which the employee is exposed because of his employment and not a risk to which any member of the general public is equally exposed.

Fisher Body Division, General Motors Corp. v. Industrial Commission of Illinois, 240 N. E. 2d 694 (1968). The claimant was injured when an automobile battery blew up in his face as he attempted to start his car by using his employer's truck in the employer's parking lot. The court held that the injury was not compensable.

9. *Huddleston v. Industrial Commission of Illinois,* 189 N. E. 2d 353 (1964). The court held that an injury sustained by the petitioner when he was assaulted by a fellow employee at job site did not arise out of and in the course of his employment, but from a quarrel which was personal in nature.

Brewster Motor Co. v. Industrial Commission of Illinois, 223 N. E. 2d 131 (1967). The court held that an automobile salesman's injuries and death resulting from a felonious attack by a customer with whom he had business dealings arose out of his employment.

10. *American Brake Shoe Co. v. Industrial Commission of Illinois,* 169 N. E. 2d 256 (1960). A claimant sought an award, claiming that his injuries were caused by a fellow employee engaged in horseplay in which he was not a participant. However, the petitioner was the only person who testified as to how the accident happened, and he made no showing of direct evidence of horseplay or anything supporting reasonable inference thereof. Therefore, an award of compensation could not be properly made.

11. *Williams v. Industrial Commission of Illinois,* 232 N. E. 2d 744 (1968). Where a butcher was not required by his employer to stand behind the meat counter when he took a coffee break, but he did so because of his own personal preference, the court held that his idiopathic fall onto the level floor of a grocery store when he choked on a doughnut and "blacked out" was a result of a personal risk and that the injuries he sustained in the fall did not arise out of the claimant's employment as a butcher.

12. *Hunter Packing Co. v. Industrial Commission of Illinois,* 115 N. E. 2d 236 (1953) An employee was found dead, on the wet floor of a toilet during working hours, lying against an electric heater which had inflicted deep burns upon his back. The court held that the fatal shock arose out of, was incidental to, and was sustained in the course of his employment. It further held that any employee engaged in work of his employer may do those things necessary to his health and comfort, even though the acts are personal, and that such acts will be considered incidental to his employment.

13. *Rysdon Products Co. v. Industrial Commission of Illinois,* 215 N. E. 2d 261 (1966). An injury to a claimant, who fell while working in a close and unventilated room on a humid day in close proximity to glue, which emitted fumes which would be harmful upon excessive inhalation, and whose duties required him to move around in an area of uneven floor, arose out of employment.

Richards v. Industrial Commission of Illinois, 254 N.E. 2d 500 (1970). A workman whose skull was crushed by a pumping unit counterweight when he went to an oil well pump to examine a box left there was killed during the course of his employment. The court concluded that the finding was supported by the evidence.

14. 128 N. E. 2d 699 (1955).

Hydro-Line Mfg. Co. v. Industrial Commission of Illinois, 154 N. E. 2d 234 (1958). The court held that injuries sustained by an employee playing baseball during his lunch period were not compensable where the employer had tentatively agreed to contribute some equipment if a team was organized.

Lybrand, Ross Brothers & Montgomery v. Industrial Commission of Illinois, 223 N. E. 2d 150 (1967). The court held that employee's death resulting from an automobile accident while he was returning from his employer's annual golf outing was compensable as arising out of and in the course of employment where attendance at the outing was based on substantial employer compulsion.

Keystone Steel & Wire Co. v. Industrial Commission of Illinois, 238 N. E. 2d 593 (1968). An employee was injured while participating in a softball game during an organized recreational activity engaged in by other employees on property owned and controlled by the employer and sponsored by the employees' association which received financial support from proceeds of employee-patronized canteens in the employer's plant. The court held that the injury was not sustained either out of or in the course of employment because at the time of the injury the employee's working hours had ended, the employer did not sponsor the game, and the game lacked any substantial business advantage to the employer.

15. *Peoria Oasis, Inc. v. Industrial Commission of Illinois,* 220 N.E. 2d 437 (1966). The claimant, an employee of the night club, was a guest at the time he was shot while helping a bartender because a waitress failed to appear for work. The court held that he was acting as an employee, and awarded compensation.

Northwestern Steel & Wire v. Industrial Commission of Illinois, 232 N. E. 2d 293 (1967). An employee was injured when he slipped and fell on his way to a timeclock after crossing a fence at the company's property line, instead of using the regular entrance. The court held that he was not precluded from recovery under the Act on the theory that use of the route over the fence placed the injury outside the claimant's scope of employment, unless the employer could show that the route taken was not a customary route of employees, that taking such route was a violation of company rules or that the route was unnecessarily dangerous.

Medical-legal review (continued)

Physician Charge of Interest to His Patients

By James L. Fletcher, ISMS General Counsel/Chicago

Essentially, a physician may charge interest on the amount due and owing from his patient in either of two situations:

1. Where there has been an express contract between the physician and the patient which authorizes the physician to charge interest; and
2. Where there is no express contract to pay interest but the physician-patient relationship falls within the provisions of Chapter 74, Section 2 of the *Illinois Revised Statutes*, 1971.

A. **Written Contract Between Physician and Patient for the Payment of Interest:**

Illinois law specifically permits individuals to enter written contracts in which it is agreed that one party pay interest to another party for monies due and owing. (See *Illinois Revised Statutes,* Chapter 74, Section 4, 1971). Where a written contract is in existence, the maximum rate of interest that may be lawfully contracted for is determined by the law applicable thereto at the time the contract is made. Presently, Illinois law permits parties to stipulate and agree to an 8% annual interest charge—any agreement for interest in excess of 8% is prohibited by law.

Contracts for interest are governed by the same rules of construction as those which apply to other contracts, the true intent of the parties is of central and controlling importance. (See *City of Chicago v. Norton,* 1870, 56 Ill. 327). If a physician is to attempt to bind a patient to a charge of interest by written contract, it is recommended that the provisions relating to interest in that written document be clear, concise, and susceptible of only one meaning.

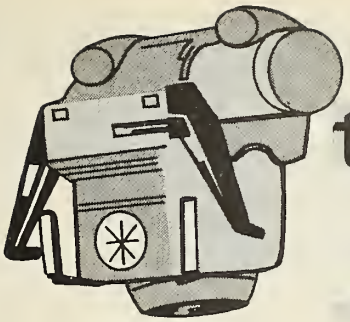
B. **Permissable Interest Charge Where No Written Contract Exists:**

If no written contract for the payment of interest exists between a physician and his patient, a physician may still be able to charge 5% per year on monies due and owing him as a creditor under four distinct statutory situations, to wit:

a) 5% for all monies after they become due on bond, bill, promissory note, or other instrument of writings;
b) 5% on money due on the settlement of account from the day of liquidating accounts between the parties and ascertaining the balance (for a discussion of the meaning of the phrase "liquidating accounts" please refer to *Windmiller v. McCartney,* 1969, 108 Ill. App. 2nd 264);
c) 5% on money received to the use of another and retained without the owner's knowledge;
d) 5% on money withheld by an unreasonable and vexatious delay of payment. (*Illinois Revised Statutes,* Chapter 74, Section 2, 1972).

In the event that a physician wishes to charge interest in a situation in which there is no written contract providing for interest, it is strongly recommended that he consult an attorney in advance of his interest charge. Chapter 74, Section 2, quoted above, is sufficiently complex and sophisticated in its legal implications and counsel should be sought for the purpose of deciding if a particular factual situation meets the intent and precise meaning of this section.

While, as has been indicated above, it is not illegal for a physician to charge interest—at least under certain, limited circumstances—the ethical considerations at issue are nontheless considerable. ◄



the view box

Leon Love, M.D./Chairman/Department of Radiology
Loyola University Stritch School of Medicine

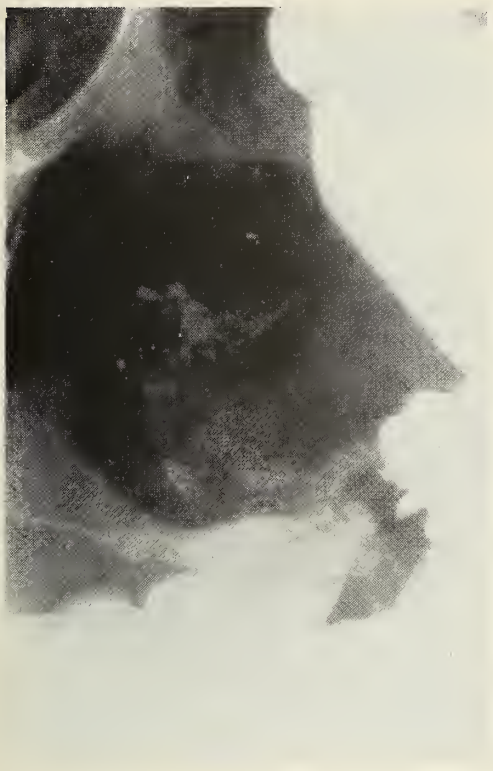


Figure 1.



Figure 2.

This patient was a 35-year-old female who had a history of left lower abdominal pain for one week's duration with a fever of 101°F. This was followed by increasing difficulty in bowel movements. Physical examination revealed a tender mass in the left lower quadrant. (Figures 1 and 2)

What's your diagnosis?

1. Diverticulitis with perforation.
2. Tuboovarian abscess with perforation into the sigmoid.
3. Carcinoma of the sigmoid.
4. Granulomatosis colitis with fitulous communication.

(Answers on page 287)

Editorials



The Results of Apathy

IS YOUR APATHY SHOWING? Most physicians have been reluctant to take an active interest in their local, state, and national medical societies. The usual excuse is, "What do they do for me?" or, "Medical societies are run by medical politicians who are not interested in my welfare." This type of reasoning has led to a noticeable apathy among physicians and our lack of harmony may sound the death knell for the private practice of medicine. Government at all levels is beginning to enact laws regulating who shall practice, how you will practice (solo, clinic, or HMO, etc.), where (urban, suburb, or rural), and how much to charge.

Our apathy has also thrown up for grabs the leadership of the delivery of health care. There are 185 million Americans with private health insurance. Insurance firms have paid $21.4 billions in benefits. Hospital insurance is big business. The American Hospital Association has called on the nation's 7,000 hospitals to take "immediate action and leadership in order to make the necessary improvement in the present health care delivery system of the United States." The federal government moves up another notch by tightening the purse strings on Medicare and Medicaid. Third party claimants are pushing to do the same for their insurees. In many communities, the "neighborhood" wants to take over the delivery of health care. And the new PSRO is really frightening.

And our apathy also extends into the way medical societies continue to ignore the 5% (or less) of the physicians who are the "bad apples." Most of us know who they are, but apparently, we never have been able to come up with a satisfactory solution to the problem. Once they have been licensed to practice in the state, the Illinois Department of Registration and Education no longer is interested in their professional conduct. But the medical society gets the blame whenever the unethical physician makes the front page. Something must be done to expose these physicians without incurring damaging lawsuits.

Perhaps the time has come for medical societies to change their approach to governmental problems. This may sound silly, but congress appears to be most attentive to vocal minorities, especially those who yell the loudest. Perhaps we should get our wives and patients to organize and fight anti-medical bills in Springfield and Washington. Our money should be spent fighting those who want to change the entire system of medicine because a small percentage of our population is dissatisfied. Stress the advantages of our system of medical care rather than always being on the defensive.

Our apathetic medical societies never seem to raise their voices immediately to the rash of erroneous propaganda against the medical community by the hoard of do-gooders, socialists, cultists, government workers, and full-time medical faculty members. But the one who really gives us a black eye is the publicity-hungry doctor who stabs us in the back in order to sell his latest book or get his name in the paper.

And why not emphasize over and over, that the government cannot provide cheaper or better medical care. Past experience has demonstrated this repeatedly.

T. R. Van Dellen, M.D.
Editor

(See Guest Editorial on page 279)

Doctor's News

HOSPITAL CONTROL OF PHYSICIANS—In an action destined to have far-reaching affects on the traditional physician-hospital relationship, a Chicago-area hospital last week revised its medical staff bylaws to transfer total responsibility for all medical care to its lay-dominated Board of Trustees.

The controversial action—resulting in the resignation of about 20 physicians from the medical staff—was taken by the Board of Trustees of the 335-bed St. Alexian Brothers Medical Center in Elk Grove, Ill.

Influenced by the 1965 Illinois Supreme Court decision in the Darling case—which held a private hospital liable for injuries to a patient—the hospital Board of Trustees revised the bylaws over the strong objections of the 120-man medical staff. However, the physicians were told that the bylaws were "non-negotiable". . . and failure to accept them was tantamount to resigning from the medical staff. The new by-laws incorporate the following features:

1. The medical staff will report—not directly to the Board—but through the hospital president;
2. Clinical department chairmen will be selected—not by the staff members—but by the Board of Trustees;
3. The medical staff executive committee—presently selected by the staff—will now be appointed by the Board of Trustees;
4. The Chief of Staff will be appointed by the Board of Trustees. The position of President of Medical Staff will be continued. The Board is considering having the president and chief of staff serve as ex-officio members of the board—without vote;
5. Recommendations on medical staff membership and privileges—previously voted on by the entire medical staff—will be made by the Executive Committee to the Board.

The hospital contends these bylaw changes are essential to fulfill its legal responsibilities under the Darling case and the State Hospital Licensing Act.

In effect, however, they: (1) Place the physicians in a subservient position in relationship to the Board; and (2) Make the Board responsible for monitoring the day to day quality of care rendered by the medical staff.

NEW RULES OF EVIDENCE DEVELOPED—A Committee of the Judicial Conference of the United States recently developed new rules of evidence that *would abolish the physician-patient privileged communication in court, except communication during psychotherapy.* However, there has been a delay of enacting the rules until the end of the first session of the 93rd Congress.

At present, ISMS is studying the new rule (Rule 5-04) and will draft recommendations. Interested ISMS members are encouraged to obtain a copy of the proposed rule from ISMS and to write a note of concern to their Representative. The AMA has testified regarding their position for continued recognition of the present physician-patient privilege.

53% PASS STATE LICENSING EXAM—A record number of 367 physicians out of 697 (53%) passed the Illinois state licensing examination which was given in Chicago last December. Illinois gained 313 physicians from those who passed the exam; the other 54 physicians will be licensed in other states. According to the Illinois Department of Registration and Education the next exam will be administered June 12-14.

ICCME HOSTING A CONGRESS—The First Annual Illinois Congress on Continuing Medical Education will meet Thursday, April 19, at the Arlington Park Towers Hotel. Invited participants include leaders of the Illinois and Chicago Medical Societies, State and Chicago specialty societies, Illinois Nurses Association, Illinois Hospital Association, and hospital DME's concerned with continuing education.

Sponsored by the Illinois Council on Continuing Medical Education, the 1973 Congress' purposes are: (1) Establish working relations between ICCME and all other Illinois professional organizations concerned to strengthen continuing medical education; (2) identify desirable CME goals for Illinois and impediments to achievement of those goals; (3) provide a working model of co-operation as a demonstration of how diverse health organizations can work together in the achievement of CME goals.

Keynote speaker will be Dr. Tom Meyer, Chairman, Department of Post Graduate Medical Education, The University of Wisconsin. The ICCME Congress Planning Committee consists of: Don Pochyly, Chairman, Eli Borkon, and Herschel Browns.

HEW AWARDS IFMC A GRANT—A $55,555 HEW grant was awarded to the Illinois Foundation for Medical Care to evaluate the quality of medical care in Illinois. **Glen Tomlinson, M.D.**, has been named chairman of a special Quality of Care Committee to supervise the project. **Bruce Flashner, M.D.**, will be a principal investigator for the IFMC project.

ANNOUNCEMENT FROM THE AMERICAN BOARD OF FAMILY PRACTICE—A two-day written certification examination for the American Board of Family Practice will be given October 20-21, 1973, in various centers throughout the U.S. Applicants should contact Nicholas J. Pisacano, M.D., Secretary, American Board of Family Practice, Inc. University of Kentucky Medical Center, Annex #2, Room 229, Lexington, Kentucky 40506. The deadline for applications is August 1, 1973.

RUSH UNIVERSITY ENCOMPASSES OTHER INSTITUTIONS—Five midwestern colleges will join with Rush University to form the nation's first educational network of affiliated colleges and universities for a coordinated program in nursing and allied health education. Eight additional colleges will be added by the end of 1973 to form a network with a total enrollment of more than 20,000.

The five initial colleges are: Illinois Institute of Technology, Chicago; Coe College, Cedar Rapids, Ia.; Cornell College, Mt. Vernon, Ia.; Knox College, Galesburg, and Monmouth College, Monmouth.

DEDICATION CEREMONIES FOR PSYCHIATRIC FACILITIES—The Marshall Field IV Center and the Stanley G. Harris Endowed Chair of Psychiatry were recently dedicated at the Rush-Presbyterian/St. Luke's Medical Center, Chicago. The bequest for the Marshall Field IV Center was donated to "enable Presbyterian-St. Luke's to create the most modern psychiatric facility possible for the Chicago area."

The Stanley G. Harris Endowed Chair of Psychiatry will assure the Medical Center the facilities and personnel it needs to provide excellent patient care and conduct pertinent research in the field of mental health. **Dr. Jan Fawcett** has been named as Chairman of the Department of Psychiatry and will occupy the Chair.

ISMS RECOGNIZES OUTSTANDING JOURNALISTS—A 14-member panel of judges recently selected 17 journalists to be recipients of the 1972 ISMS Journalism Awards. The Journalism Awards, which recognize journalists for distinguished achievement in medical journalism, is sponsored by the ISMS Council on Public Relations and Membership Services.

The winners were selected from 140 entries in the categories of radio, television and newspapers. Downstate daily newspapers contributed the highest number of entries with 54.

This is the ninth year that ISMS has sponsored the Journalism Awards. The winners will receive plaques to be presented at the Journalism Awards Banquet on May 19, at the Sheraton-Chicago Hotel.

Lee F. Winkler, M.D., Chairman of the Council announced the following winners: Ronald Kotulak, *Chicago Tribune;* James Pearre, *Chicago Today;* Arthur Snider, *Chicago Daily News;* Charles-Gene McDaniel, *Associated Press;* news staff, *Aurora Beacon-News;* Jim Mansfield, *Peoria Journal-Star;* Barbara Chapman, *Rockford Morning Star;* Dave Ramacitti, Davenport (Iowa) *Times-Democrat;* Bruce Srachta, *Tinley Park Times-Herald;* Joanne Goldstein and Holly Sembrat, *Pioneer Press,* Wilmette; Michael Larson and Marcia Heller, *Mundelein Herald.*

Radio-TV winners include: Bob Hale and Bettye Odum, *WMAQ-TV,* Chicago; staff, *WLS Radio,* Chicago; Bob Murray, *WMAY Radio,* Springfield; Roger Wolfe, *WICS-TV,* Springfield; Lee Phillip and Julian Barber, *WBBM-TV,* Chicago.

DONATION RECEIVED FOR ISMS SCIENTIFIC SPEAKERS BUREAU—Mr. Jack Reig, Midwest Regional Manager, Merck, Sharp & Dohme, presented ISMS $3,000 for the Scientific Speakers Bureau. The Speakers Bureau provides qualified physicians to speak at county medical society meetings. MSD has funded this educational program for many years.

IDPA DIRECTOR APPOINTED—Governor Dan Walker has named **Joel Edelman** Acting Diector of the Department of Public Aid. Edelman has served as Executive Vice President at Michael Reese Hospital and Medical Center for 11 years.

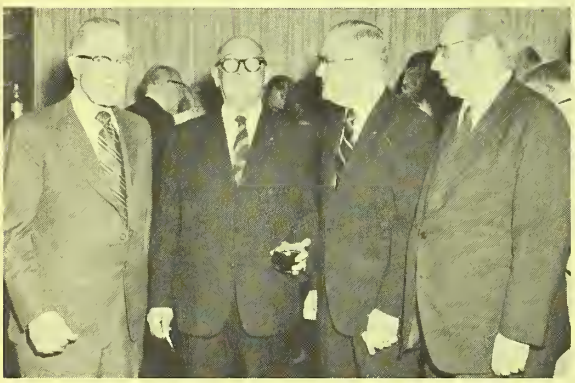
PHYSICIANS IN THE NEWS—**Ronald M. Johnson, M.D.**, Villa Park, a resident in surgery at the University of Illinois at the Medical Center, Chicago, received Chicago's Institute of Medicine's 1972 Joseph A. Capps Prize which honors young medical researchers. The prize, a $750 cash award, noted Dr. Johnson's scholarly paper "Treatment of Acute Pancreatitis: In Search of a Rationale."

Thomas W. Lester, Jr., M.D., has returned to the University of Chicago as a Professor in the Department of Medicine. **Clement R. Brown, M.D.**, Director of Medical Education, Mercy Hospital, Chicago, has been appointed to the Association of American Medical Colleges Health Services Advisory Committee for a three-year term.

Robert Maloney, M.D., Carbondale, has been elected President of the Illinois Obstetrical and Gynecological Society. **Oswald Mowatt, M.D.**, Chicago, has been appointed Medical Director of Provident Hospital, Chicago. New appointments at Rush University include **L. Penfield Faber, M.D.**, as Associate Dean for Surgical Sciences and Services.

Walter Dillon, M.D., of the OB-GYN Department at Mercy Hospital, Chicago, has been appointed to the Mercy Hospital Board of Directors. **Leonard V. Gratkins, M.D.**, has been awarded a Charter Fellowship by the American Academy of Family Physicians. Dr. Gratkins is a member of the Family Practice Department of Mercy Hospital and Medical Center, Chicago. **Arthur S. Billings, M.D.**, Attending Physician, Department of Medicine, Michael Reese Hospital and Medical Center, has been elected as Trustee of the institution.

FAREWELL FOR DR. BORNEMEIER



Friends of Walter C. Bornemeier, M.D., recently gathered at the Chicago Lung Association office to bid farewell to this physician dedicated to organized medicine and civic organizations who is retiring from the medical field. Pictured with Dr. Bornemeier (third from the left) are: J. Ernest Breed, M.D., Past President of ISMS; Morris Fishbein, M.D., former editor of JAMA and is the editor of the **MEDICAL WORLD NEWS** and Maurice Hoeltgen, M.D., past ISMS Speaker of the House.

WALTER C. BORNEMEIER, M.D., RETIRES

Walter C. Bornemeier, M.D., a Chicago surgeon, is retiring after fulfilling many devoted years to the medical profession, organized medicine and civic organizations. Dr. Bornemeier was nominated by the Illinois State Medical Society to be President-Elect of the American Medical Association in 1969. In June, 1970, he was installed as the 125th President of AMA. He had previously served as Speaker of the AMA's House of Delegates and had served as Vice-Speaker for three preceeding years.

As an active ISMS member, Dr. Bornemeier served as Trustee in 1949, Speaker of the House of Delegates, 1961-1964, and Chairman, Committee on Constitution and Bylaws. In addition, Dr. Bornemeier was active in the Chicago Medical Society and was President in 1954.

Former President of the Chicago Lung Association (formerly the Tuberculosis Institute of Chicago and Cook County), Dr. Bornemeier devoted 20 years to the organization as a Director and member of the Executive Committee.

He served as Trustee for Blue Shield (Illinois Medical Service) and was a member of the Executive Committee for the Health Division, Welfare Council of Metropolitan Chicago.

As a community leader, Dr. Bornemeier was President of the Niles Township High School Board of Trustees, member of the Skokie Valley YMCA, and President, the Associates at North Central College, Naperville.

He received his medical degree from Northwestern University and taught surgery there for 20 years. Dr. Bornemeier was Senior Attending Physician at Illinois Masonic Hospital.

Dr. and Mrs. Bornemeier have left Chicago to reside in California.



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investment corner

By Lloyd A. Byerhof, Partner
Peat, Marwick, Mitchell & Co./Chicago

RENTAL VACATION HOMES AND TAXES

Rental vacation homes are becoming attractive to many doctors. Often these properties are purchased for their potential long term appreciation, as well as their short range potential for cash flow from rental income. Frequently deductions, including depreciation exceed the rental revenues. Thus, an individual may attempt to offset rental losses against other taxable income.

An important provision (Section 183) was added to the Internal Revenue Code by the Revenue Reform Act of 1969. It provides that in the case of an activity engaged in by an individual or a subchapter S corporation, if such activity is not engaged in for profit, no deduction attributable to such activity shall be allowed except:

. . . Deductions otherwise allowable for the taxable year without regard to whether the activity is engaged in for profit (interest, property taxes, casualty losses, etc.), and

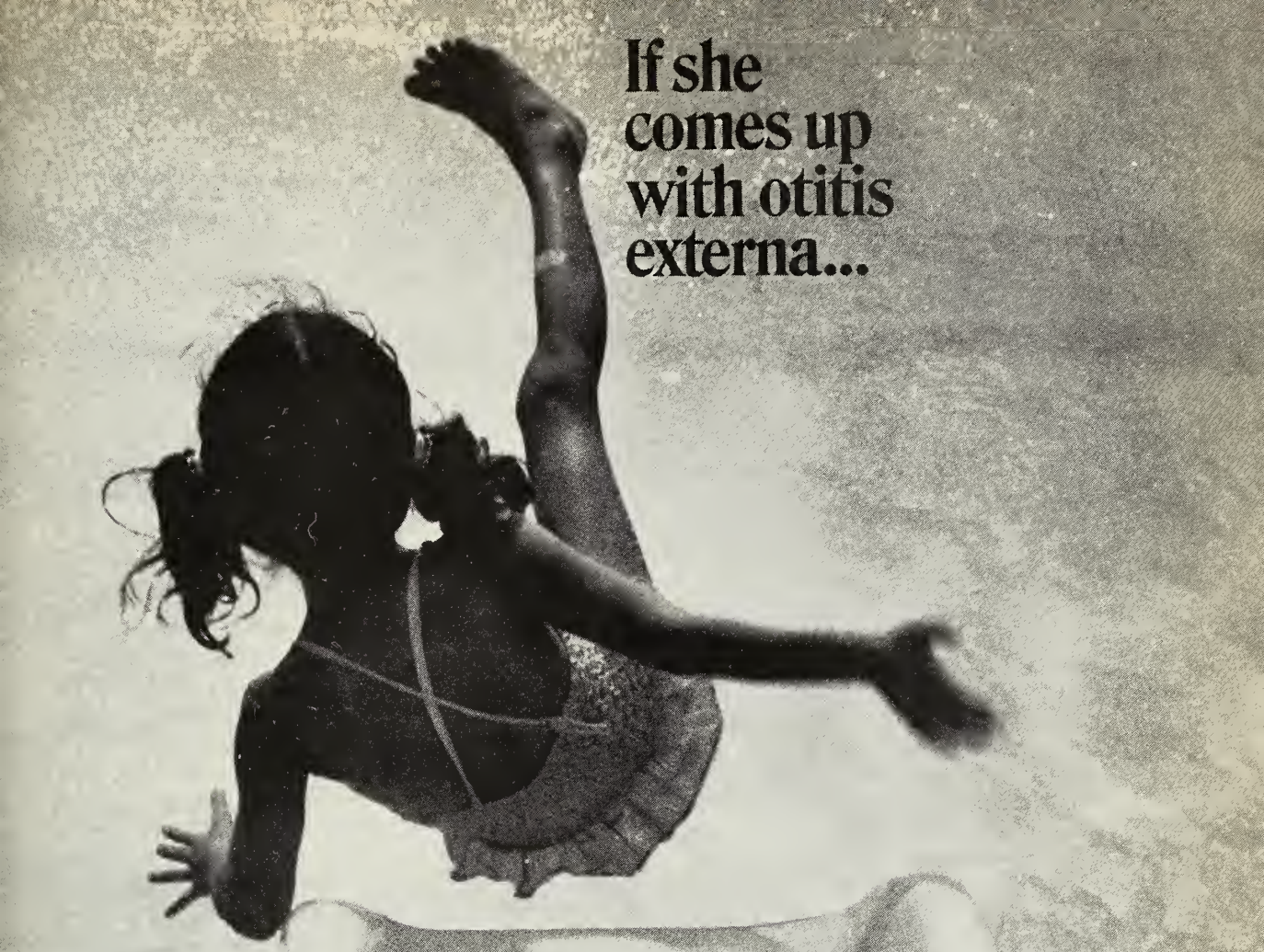
. . . A deduction equal to the amount of the deductions which would be allowable if the activity *were* engaged in for profit, but only to the extent that the gross income derived from the activity for the taxable year exceeds the deductions described above (i.e., interest, property taxes, etc.).

To illustrate the new rule, let us assume the doctor owns a rental vacation home in Florida and the rental activity is *not* engaged in for profit. Assume further than the normal rental season is six months; the taxpayer personally occupies the residence during one month of the season, and the residence is available for rent the other five months.

Situation B illustrates the advantage of using a taxpayer's personal funds to purchase the ren-

(Continued on page 278)

	Situation A	Situation B
Rental income	**$2,500**	**$2,500**
Deductions otherwise allowable:		
Interest	**(1,000)**	**None**
Real estate taxes	**(500)**	**(500)**
Amount of income remaining to offset other expenses	**1,000**	**2,000**
Other expenses:		
Maintenance (5/6 of $600)	**500**	**500**
Utilities (5/6 of $300)	**250**	**250**
Depreciation (5/6 of $1,200)	**1,000**	**1,000**
	$1,750	**$1,750**
Other expenses not deductible	**$ 750**	**None**



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Each ml contains: Colistin base activity, 3 mg (as the sulfate); Neomycin base activity, 3.3 mg (as the sulfate); Hydrocortisone acetate, 10 mg (1%); Thonzonium bromide, 0.5 mg (0.05%). Polysorbate 80, acetic acid, and sodium acetate in a buffered aqueous vehicle. Thimerosal, 0.002%, added as a preservative. *Indications:* Coly-Mycin S Otic with Neomycin and Hydrocortisone is indicated in the treatment of acute and chronic external otitis due to or complicated by bacterial and/or fungal infections caused by susceptible organisms. It is also indicated for the prophylaxis of "swimmer's ear." *Contraindication:* A history of sensitivity to any of the components or in tubercular, fungal and most viral lesions, especially herpes simplex, vaccinia and varicella. *Precautions:* If sensitivity or irritation occurs, medication should be discontinued promptly. Overgrowth of resistant organisms is possible. Use with care in cases with perforated eardrum or in long standing otitis media because of the possibility of ototoxicity caused by neomycin. There are articles in the current medical literature that indicate an increase in the prevalence of persons sensitive to neomycin. *Adverse Reactions:* A low incidence of mild burning or painful sensation in the ear has been reported. Such local effects do not usually require discontinuance of medication. Sensitivity reactions were reported in a few instances. *Administration and Dosage:* After the ear has been completely cleansed end dried, Coly-Mycin S Otic with Neomycin and Hydrocortisone should be instilled (a sterile dropper is provided) into the canal, or applied to the surface of the affected ear. Shake the suspension well before using. The recommended therapeutic dosage is four (4) drops, 3 times a day; prophylactically, four (4) drops before and after swimming. Until acute pain has subsided, it may be preferable or necessary in some patients to pack the ear with a cotton wick saturated with Coly-Mycin S Otic with Neomycin and Hydrocortisone. The wick should be kept wet at all times. The patient should be instructed to avoid contaminating the dropper, especially with the fingers. Coly-Mycin S Otic with Neomycin and Hydrocortisone is stable for eighteen (18) months at room temperature; however, prolonged exposure to higher temperatures should be avoided. *Supplied:* Coly-Mycin S Otic with Neomycin and Hydrocortisone is available in bottles containing 5 ml or 10 ml. Each ml contains 3 mg of colistin base activity (as the sulfate), 3.3 mg of neomycin base activity (as the sulfate), 10 mg of hydrocortisone acetate, 0.5 mg of thonzonium bromide, polysorbate 80, acetic acid and sodium acetate. A small amount (0.02 mg/ml) of thimerosal has been added as a preservative. Each package contains a sterile dropper. Full information is available on request.

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CMO-GP-31B-BW

Rental Vacation Homes . . .

(Continued from page 276)

tal vacation home. Since there is no interest directly attributable to the property, this leaves more rental income after taxes to offset other expenses. Please note that the Internal Revenue Service may attempt to allocate interest on "personal" indebtedness to the rental vacation home where it appears to be indirectly related.

Under the new rules, if in two or more years in a period of five consecutive taxable years the gross income derived exceeds the related deductions, the activity is presumed to be engaged in for profit unless the IRS proves otherwise. As a planning consideration, a cash basis taxpayer may be able to control the year in which expenses and income are recognized to show a profit in the desired years.

Even if a taxpayer fails to meet the presumption tests described above, non-personal deductions relating to an activity are allowable if it can be established that:

- . . . The activity is a trade or business, or
- . . . The deductions were paid or incurred for the production or collection of income or management, conservation or maintenance of property held for the production of income.

Deductions are not allowable under these two exceptions for activities which are carried on primarily as a sport, hobby, or for recreation. Therefore, the taxpayer would have to establish that the predominant purpose and use of the rental vacation property is for production of income. In this regard, it is an established principle that a taxpayer making a dual use of property, e.g., business and personal, can allocate expenses and depreciation to that part of the use which relates to earning income or making a profit.

However, the business part of the activity must be of such nature that, in good faith, the taxpayer could expect a profit and the profit expectation must be the dominant motive for engaging in the activity. In determining whether an activity is engaged in for profit, the Regulations indicate that greater weight is to be given to objective facts than to the taxpayer's mere statement of intent. Among the factors:

- **. . . The businesslike manner in which the taxpayer carries on the activity,**
- **. . . The expertise of the taxpayer or his advisors,**
- **. . . . The tax and effort expended by the taxpayer,**
- **. . . An expectation that assets used in the activity may appreciate in value,**
- **. . . The taxpayers history with respect to the activity,**
- **. . . The amount of occasional profit, if any, which is earned,**
- **. . . The financial status of the taxpayer,**
- **. . . The elements of personal pleasure or recreation.**

The new rules make it extremely important to document the profit motive and how this potential profit will be realized for rental vacation homes. Periods of personal use will have to be severely limited, if tax losses in excess of income are to be claimed. Each taxpayer will have to review his facts and circumstances with his personal tax advisor to determine whether he has protected himself as much as is possible in documenting his profit motive and profit potential. ◄

President's Page

(Continued from page 213)

people is to be found in what people do and don't do, to and for themselves."

Apathy towards personal health . . . the question of how much and what to eat, drink and smoke . . . the need for regular exercise . . . the ignorance of what to do . . . where to begin. This is an area that requires extensive effort.

We hear "talk of the politicians" concerning the consumer's role in the health field. Put him on hospital boards, let him run the organizations from the local level, let him decide where and how many medical facilities he needs. This is not the answer to our health care problems. It's only a new form of "treatment."

If we want to include the consumer on the local level in a worthwhile and meaningful manner, put him in command of the projects that truly need his leadership abilities. Get the consumers on the local level to organize a health education program through the school system that will serve both children and adults, organize information programs on nutrition and "healthful living," petition for a reallocation of health dollars.

Instead of following the proposals that call for "twentieth century assembly line medicine" . . . let's propose and initiate our own solution.

If we start at the beginning . . . if we teach the public how to live "healthy lives" . . . we CAN preserve this system . . . we CAN preserve that personal touch that effective health care demands.

Maybe we all need a good swift kick to get us started. ◄

Frank J. Jirka, Jr. M.D.

Guest Editorial

"Let's Stamp Out Venereal Glaucoma"

Susan is that bright-eyed youngster you delivered sixteen years ago. She is now in your office complaining of lower abdominal cramps, vaginal discharge and irregular periods. She is *actually* there because she fears that she has contracted veneral disease.

You give her a routine examination and assure her there is no gross abnormality. She leaves falsely reassured; she *assumes* you have checked her for venereal disease.

Gonorrhea has come into your office, but you have failed to acknowledge its presence. You have joined that too large group of physicians who say, "Venereal disease? I haven't seen a case in twenty years; not in *my* practice!"

Many physicians have developed venereal glaucoma; they view the venereal disease epidemic with narrow tubular vision as a public health problem unrelated to their own practices.

Venereal disease is certainly a public health problem. The patients being treated in VD clinics represent only the tip of the iceberg!

Practicing physicians must realistically face these facts:

1) The vast majority (an estimated 80%) of cases of venereal disease are being treated privately, not in the VD clinics.

2) VD is not a disease peculiar to the lower socioeconomic population; it hits all levels of society. It is no respector of social or economic position, color, race, age or sex.

3) Social and sexual mores are changing: premarital intercourse is common, and at an increasingly younger age; and anal and pharyngeal gonorrhea are appearing with increasing frequency in both sexes. The downgrading of the condom as a means of prophylaxis and contraception and the widespread use of birth control pills have provided a fertile ground for the optimum growth of the gonococcus in the host patient.

The private physician must join the active public health agencies and educators if venereal disease is to be controlled. He must take the following steps:

1. Think VD! Have a high index of suspicion, and tactfully ask about possible exposure.

2. Whenever VD is suspected, do appropriate laboratory tests. Draw a VDRL serology for syphillis in both sexes. Take a smear and culture of the male with a urethral discharge. Take an anal and cervical culture in the suspected female.

3. Treat venereal disease with adequate dosage. Early syphillis is treated with 2.4 million units of benzathine penicillin. Gonorrhea is treated by crystalline procaine penicillin G 4.8 million units in at least two sites intramuscularly, preceded at least 30 minutes before by 1 gm of probenicid orally. Spectinomycin 2 gm IM in the male, and 4 gm IM in the female is an alternate therapy for the penicillin-sensitive patient. Another alternate therapy is tetracycline 1.5 gm stat, followed by 0.5 gm QID p.o. for four days.

4. Be sure to report the case to either your local or State Health Department. Assure your patients that all followup studies will be absolutely confidential and that never will the source of the contact be divulged.

5. If you are not equipped to diagnose and treat venereal disease, you owe it to your patient to refer him to other physicians who are so equipped, or to the local VD clinics. Inadequate diagnosis, treatment and followup are intolerable.

There is an ongoing dispute as to whether the physician should treat epidemiologically or clinically. This arises when a male appears with a thick, burning urethral discharge before laboratory results are back, or where the patient gives a highly suggestive history of exposure. ("John was told he had syphillis at the VD clinic. I had intercourse with him.") Each physician must decide for himself whether he will treat pending the laboratory results (epidemiological treatment) or whether he should wait and treat only disease he has proved (clinical treatment). But in either event, he should secure appropriate tests, and should insure that adequate contact followup is instituted.

The private physician holds the key to the control of venereal disease; he must use that key to lock the door against the spread of this scourge.

Walter Lentino, M.D., *News of New York*

(Another Guest Editorial on page 293)

practice management



Is There Negativism in Your Practice?

By Richard B. Currie, Senior Consultant
Professional Business Management, Deerfield

Have you ever tried to get waited on in a large department store about half an hour before closing time? Or, for that matter, any other time? The prevailing attitude of the clerk seems to be, "This wouldn't be a bad job if it weren't for the customers." This negativism can be found in any business, and can "play hell" with public relations. Think what it can do to your practice.

It is true that your job would be much easier, and your assistants would be happier if it weren't for all the patients and their problems? Of course, this is ridiculous; but from some of the observations we have made in our continuing contacts with medical practices, such an attitude of negativism does exist and can easily undermine your public relations.

To the patient in trouble, the doctor is the second most important person in the world; the first, naturally, being the patient. Anything less than the utmost courtesy and concern is unacceptable to her or him no matter how unassuming their attitude seems to be. Anyone in the medical profession is fully aware of this, but there apparently is a tendency to forget when things are closing in and the pressures of a large practice seems to be overwhelming.

If you have been in practice any time at all, you know that it is difficult to maintain the sort of attention and interest that each patient wants, and, in their mind, needs. However, you also know that a negative attitude must not show, and this is an almost impossible task. If your practice is large and your patient load is heavy, you have learned to delegate some of the public relations work to your assistants.

Beside the obvious duty of answering your telephone, your assistant sees the patients first and is your representative in dealing with them after they have talked to you. Your assistant's personality and tact will, and should, become a reflection of your own; but you must be aware of establishing two attitudes, one which the patient sees and hears—the familiar "bedside manner"—and the other, more candid one with which your assistants become familiar.

Some of your aides, your nurse for example, are with you when you talk to your patient and are able to observe your attitude and personality at that time; but you may have others, your receptionist, bookkeeper or office manager, who only see the patient before or after your examination. If you have two attitudes, they may only know the negative one.

Remember the old radio show, or perhaps you are too young, where the timid salesman knocked on the door, muttering to himself, "Nobody home, I hope, I hope, I hope?" This example, as well as the attitude of the jaded sales person, is one of negativism and must be avoided. It would be well to occasionally stop and reflect on the attitude in your practice. If you recognize negativism anywhere, it is time to eliminate it before it goes too far. ◄

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EKG of the month

(Continued from page 249)

Answers: *A-5; B-5; C-3*

The electrocardiogram demonstrates periods of sinus arrhythmia seen best in V_2 and V_3. In V_4, V_5 and V_6 periods of junctional (nodal) rhythm are seen. In lead II, after the second QRS complex, a premature atrial beat is seen as a P wave. However, because of its occurence during the refractory period of the A-V node, the premature atrial beat is not conducted to the ventricles. Sinus arrhythmia alternating with periods of junctional rhythm is a normal ECG finding in children related to their increased vagal nerve supply to the sinus node. Occasional premature atrial beats are not infrequently seen in children and are considered normal unless they occur frequently or from multiple foci.

The significant abnormality seen is the repolarization abnormality (T-wave changes) seen in V_2 and V_3. The symmetrically deep, inverted T-wave in V_2 could indicate localized myocardial ischemia as is seen in obstructive coronary artery disease or due to myocardial damage as is seen in viral myocarditis or after use of psychotropic drugs, such as Elavil or Tofranil. From the clinical record none of the above causes could be substantiated. Pericarditis can also produce these T-wave changes. However, the cardiac examination was normal.

ECG changes without demonstrable cardiac causes have been found in some patients with CNS disease. The ECG abnormalities which can be seen with CNS disease are large upright T waves, deeply inverted T waves with or without prolonged Q-T intervals, tall P waves, ST-displacement, or prominent U waves.

Although the exact mechanism by which CNS disease alters repolarization is not known, Finkelstein and Nigagliani postulated that the ECG changes represent an alteration in myocardial function brought about by a temporary state of excessive vagal and sympathetic stimulation.

Intracranial stimulation of the sympathetic nervous system may occur in the motor and premotor area of the cortex, in the posterior hypothalamus, mid braid, pons, medulla and their connections. The parasympathetic nervous system is concentrated in area 13 which lies on the orbital surface of the frontal lobes and has a relay station in the anterior hypothalamus. Blood vessel of the Circle of Willis have sympathetic and parasympathetic nerves from cranial nerves 9 and 10, and from a continuation of the cervical sympathetic chain. Parasympathetic stimulation from rupture of a Berry aneurysm in the area of Circle of Willis or the carotid siphon may account for the ECG abnormalities frequently seen following a subarachnoid hemorrhage. Elevation of intracranial pressures such as from internal hydrocephalus causing excessive parasympathetic or sympathetic stimulation would account for the ECG changes in the absence of clinical heart disease. ◄



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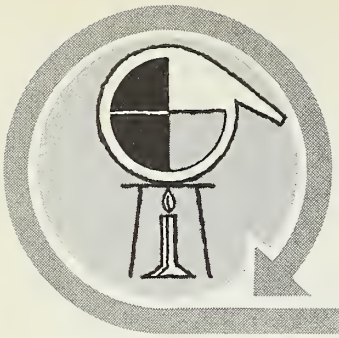
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new pharmaceutical specialties

By Paul Dehaen

For detailed information regarding indications, dosage, contraindications and adverse reactions; refer to the manufacturer's package insert or brochure.

Single Chemicals: Drugs not previously known, including new salts.

Duplicate Single Drugs: Drugs marketed by more than one manufacturer.

Combination Products: Drugs consisting of two or more active ingredients.

New Dosage Forms: Of a previously introduced product.

The following new drugs have been marketed:

DUPLICATE SINGLE DRUGS

NOR-Q.D. Progesterone ℞
Manufacturer: Syntex

Nonproprietary Name: Norethindrone

MICRONOR
Manufacturer: Ortho Pharmaceutical Corp.
Indications: Contraception
Contraindications: Thrombophlebitis, thromboembolic disorders and related conditions.
Warning and Precautions: See package insert
Dosage: Continued daily administration of one tablet
Supplied: Tablets

PEN A CAPS Antibiotics ℞
Manufacturer: Pfizer Laboratories
Nonproprietary Name: Ampicillin Trihydrate
Indications: Treatment of infections caused by susceptible organisms.
Containdications: History of allergic reactions to penicillin
Dosage: See package insert
Supplied: Capsules, 250 & 500 mg. = ampicillin

PEN A/N for Injection Antibiotics ℞
Manufacturer: Pfizer Laboratories
Nonproprietary Name: Ampicillin Sodium
Indications: Treatment of infections caused by susceptible organisms.
Contraindications: History of allergic reactions to penicillin
Dosage: See package insert
Supplied: Vials 250, 500 mg. and 1 gm.

ROBIMYCIN Antibiotics ℞
Manufacturer: A. H. Robins Company
Nonproprietary Name: Erythromycin
Indications: Treatment of infections caused by susciptible organisms.
Contraindications: Known hypersensitivity
Warning: Safety of use in pregnancy has not been established.
Adverse Reactions: Most frequently observed: gastrointestinal
Dosage: See package insert
Supplied: Tablets, 250 mg.

COMBINATION PRODUCTS

DARVOCET-N Analgesic ℞
Manufacturer: Eli Lilly & Company
Composition: Propoxyphene Napsylate 50 mg.
Acetaminophen 325 mg.
Indications: For mild pain and febrile conditions
Dosage: 2 tablets every 4 hours
Supplied: Tablets

POLY-VI-SOL with IRON Vitamins & Iron o.t.c.
Manufacturer: Mead Johnson Laboratories
Composition: Nine Vitamins
Iron 10 mg.
Indications: Iron deficiency in anemia
Supplied: Drops, bottles 50 cc.

NEW DOSAGE FORMS

MINOCIN INTRAVENOUS Antibiotics ℞
Manufacturer: Lederle
Nonproprietary Name: Minocycline HCl
Indications: Treatment of infections caused by susceptible organisms.
Contraindications: Similar to those with tetracycline compounds
Dosage: Follow package insert
Supplied: Vials, 100 mg.

MINOCIN SYRUP Antibiotics ℞
Manufacturer: Lederle
Nonproprietary Name: Minocycline HCl
Indications: Treatment of infections caused by susceptible organisms.
Contraindications: Similar to those with tetracycline compounds
Dosage: Follow package insert
Supplied: 50 mg./5 cc.
Bottles, 2 fl. oz.

TETRAL ELIXER Bronchodilators ℞
Manufacturer: Warner Chilcott
Composition: Each 5 cc. contains
Theophylline 32.5 mg.
Ephedrine HCl 6.0 mg.
Phenobarbital 2.0 mg.
Indications: Symptomatic relief of bronchospasm associated with bronchial asthma.
Contraindications: Porphyria
Dosage: In general, 1 teaspoon for each 60 pounds body weight every four hours; adjust to age.
Supplied: Bottles 16 fl. oz.

VALISONE AEROSOL Corticosteroid, Local ℞
Manufacturer: Schering Laboratories
Nonproprietary Name: Betamethasone Valerate
Indications: Adjunctive topical management for the relief of inflammatory manifestations of acute contact dermatitis.
Contraindications: Those usual for local corticosteroid therapy
Warning: Keep away from eyes and other mucous membranes
Dosage: Applied for 3 sec. at 6 inch distance
Supplied: Aerosol, 0.15%
9.1 mg. betamethasone valerate per container

Better Know What's Going on at the Statehouse!*

What the legislature does affects you every day. You can make it work for you far more than you realize.

THE PUBLIC'S INTEREST in state legislatures is not what you'd call glowing hot. On the average person's list of priorities they probably rank somewhere behind the bowling night or the weekly bridge game.

But what's going on at the state capital is going to touch you sooner or later, so you really should know how the game is played.

Remember, it's the state that issues birth certificates and burial permits. You probably pay state income taxes or sales taxes or both. You have to have a state license to marry, to teach, to practice medicine, law or any number of other callings, to drive a car, to hunt or fish. An act of your state legislature could send a new superhighway right through your neighborhood. State legislatures also borrow money, authorize elections, create civil and criminal laws and courts, authorize and regulate banks and public utilities, charter corporations, operate and support public schools and colleges, run prisons and parole boards, build hospitals and set the ground rules by which your local government operates.

Unless you live in Kentucky, your state legislature is meeting this year—this month, except in Alabama, Florida, Louisiana and Tennessee where sessions will convene later.

The purpose of this article is to give you an idea of how a state legislature works and to show you ways you can get your views before it.

Theory is one thing . . .

LIKE THE U.S. CONGRESS, every state legislature except Nebraska's has two houses, or chambers, usually a senate and a house of representatives. Nebraska has a unicameral or single chamber legislature; its members are all senators. While each state's legislature has a little different way of doing things—in Massachusetts, for instance, any citizen can introduce a bill in the legislature—most of them operate quite similarly.

Ideally, in the case of a bill that moves smoothly through the legislature, the law-making process begins with introduction of the bill in either house. It is given a perfunctory reading by the clerk and is given a number and assigned to a committee for study. From the committee it goes to the floor for debate and amendment and is voted up or down by the legislators. If it passes, it goes through the same procedure in the other chamber. If it survives there, it goes to a joint conference committee where differences in the two chambers' versions of the proposed law are worked out. Then it goes back to both chambers for a final vote, thence to the governor for his signature or veto.

In practice it's not so simple. Several thousand bills are introduced in your legislature each session. All will be competing for attention, and at any number of points along the way the bill of most interest to you may be sidetracked or killed without having reached the floor for a full debate or without having received a public hearing or even having been seen by more than a handful of legislators.

For a bill to travel successfully through a legislature, its supporters—in and out of the legislature—must work hard for it. The work may start even before a bill is drafted, when it is just an idea, and it may involve efforts beyond the confines of the statehouse—community meetings, letter writing campaigns, marches on the capitol. All kinds of forces will be working for and against the bill: legislators, professional lobbyists, agents for cities and counties, special-interest groups and individuals.

Because of the part-time nature of most state legislators' duties, the men and women who are legislators usually have the kinds of full-time jobs flexible enough to permit them the time to attend to legislative work. Traditionally, they are lawyers, for the most part, and real estate and insurance people, and the self-employed. Very little clerical help is provided for legislators; a secretary might be assigned to a committee, but rarely to individual legislators. Few states provide legislators with professional staffs to research issues, solicit expert testimony on bills or handle inquiries from constituents.

For these and other reasons state legislatures have earned reputations as less than truly representative assemblies. Terry Sanford, former governor of North Carolina, has said public indifference keeps them weak and ineffective and "only helps special interests dominate the legislature." John Gardner of Common Cause has said they are with some exceptions "marked by wholesale corruption at worst and mediocrity at best." Another critic recently wrote that most of them still are in government's backwater: "This is why in most states mining companies still write mining laws, insurance companies the insurance laws, bankers the banking laws. It is why we have an automobile insurance crisis in almost every state; why billboards still clutter our countryside; why the pollution control boards of most states are dominated by the polluters themselves."

Lest you think the scalawags have run away with your state government, though, it should be noted that the U.S. Supreme Court's "one man, one vote" reapportionment decisions in the early 1960's have helped make legislatures more representative bodies. At the same time a broad-based reform movement has recently brought about considerable improvement in the way legislatures are run—annual sessions, open hearings, increased salaries, professional staff help, ethics and conflict-of-interest laws. The legislatures in California, Florida and Hawaii now are considered among the most modern and efficient in

*This article appeared in CHANGING TIMES *The Kiplinger Magazine*, January, 1973, pp. 27-29. (Reprinted by permission.)

the nation. There were legislative reform items on the ballot in 22 states last November.

Lobby a little yourself

ORGANIZED SPECIAL INTERESTS of all kinds—those you would applaud as well as those you might deplore—have agents pressing their viewpoints full-time. If you want to get your views before the legislature and you're willing to spend some time and energy doing it, here's what you need to do:

Learn all you can about your legislature. Find out where the real power lies. For instance, the legislator who controls the assignment of a bill to committee can send it to one whose members will favor its further passage through the chamber or to one where it will be opposed. Be alert to the introduction of bills that concern you and to the scheduling of hearings where you can testify. Follow the legislature in your local newspaper. Check on its progress at the local office of your political party or from your own legislator. Some state legislatures publish official periodic reports containing synopses of bills, notes on dates for hearings or votes, and the like. You can usually get copies from the chief clerk of the legislature or through your legislator or political party office.

Get to know your legislators. Unless you're a Nebraskan, there'll be at least two of them from your voting district. Call, write or visit them to express your interest in legislation under consideration. Let them know you're keeping up with their work. Don't waste their time. Discuss the issues in specific terms. Never copy your letter from a master form; make your points in your own personal fashion. An excellent way to make the acquaintance of your legislators, of course, is to work in their election campaigns or to invite them to address groups you belong to.

Work within a group. It could be a political party; or a nonpartisan group like the League of Women Voters, Common Cause, a civic association; or a special-interest organization like a chamber of commerce, a conservation club, an auto club. Well-organized groups often keep their members posted on key legislation and how it would affect members of the group. If there is no organization taking up the cudgels for your issue, start one yourself. That's how many special-interest groups get started. Remember, groups have more heft than individuals acting alone; by spreading the work among their members, they can get a lot more accomplished in a lot less time.

Do your homework. Governors and lobbyists initiate most of the important legislation passed by state legislatures. Lobbyists are often the main source of research for state legislators. The best professional lobbyists provide fast, accurate information that presents their point of view in factual terms. Take a tip from them. Prepare your case well, go armed with facts, present them succinctly and forcefully, and leave resource material with your legislators.

Start early. Begin lining up support for a bill well ahead of a legislative session. Once a bill clears committee (or gets into a committee in some cases), it's usually too late to influence its fate. In many states now the legislature's work goes on year-round through interim or standing committees that function between sessions and are able to prefile bills at any time of the year. Thirty-nine state legislatures meet annually now; California and Massachusetts have essentially full-time legislatures.

Work for reform. This may be the only way you can assure that your views will be heard, especially if your legislature is a rusty model. For starters read the comprehensive report of the Citizens Conference on State Legislatures, *The Sometime Governments* (Bantam, $1.95). And next election time, vote for candidates who will back needed reforms. ◄

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Bone Cysts in Renal Disease

(Continued from page 257)

Parathyroidectomy should not carry with it a great mortality or morbidity. The patient was subjected to this operation and she will feel much better because of that operation. We must be careful of the anesthetic in patients with severe renal disease. Following the bone biopsy, she slept for two days as the usual dose of anesthesia was too much for her. We were careful with the parathyroidectomy anesthesia. She was awake in the recovery room and had an uneventful course and went home.

Dr. John Beal: Did you identify all of the parathyroid glands?

Dr. James Hines: In these cases, you must identify all four parathyroids before resecting any of the glands. If in doubt, you identify all by a small biopsy. You then remove the half gland first to be sure the remainder is visible Then you take out the other three.

Dr. John Beal: Did you send a little piece of each to Dr. Battifora for frozen section during the operation?

Dr. James Hines: During the operation we sent three pieces, as well as a couple of lymph nodes. You must identify all four of the glands. If all parathyroid tissue is removed or even devitalized, your patient may become hypoparathyroid. This is more difficult to control than hyperparathyroidism. ◄

View Box

(Continued from page 269)

Diagnosis: *Tuboovarian abscess*—At surgery a tuboovarian abscess was demonstrated in the left lower abdomen which had perforated into the sigmoid. This is one of the complications which may occur with acute pelvic inflammatory disease and should always be considered in the differential diagnosis in a female patient. Perforation into the sigmoid is an unusual complication, but has been reported as a possible sequela in this condition. The radiographic appearance is that of an extrinsic mass with compression of the sigmoid and extravasation of barium into the pelvic area. The lack of diverticula and the length of the segment would tend to lessen the possibility of diverticulitis or carcinoma as a diagnosis. There is no definitive evidence of granulomatosis disease; however, this would be difficult to exclude. ◄

PHYSICIANS

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A well-known, research-oriented institution in western suburban Chicago offers excellent arrangement, including convenient, mutually agreeable hours.

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Approximate time required for part-time work is 20 hours per week—specific hours are flexible and a convenient schedule can be arranged that dovetails with the Physician's other commitments.

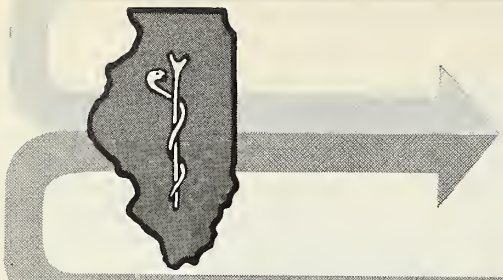
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report

Illinois Society
American Association of Medical Assistants

Illinois Society, American Association of Medical Assistants

17th Annual Meeting

Tomorrow's Galaxy

April 27-29, 1973

Pheasant Run Lodge, St. Charles

Friday, April 27, 1973

8:30 A.M.	Council Meeting
1:00 P.M.	House of Delegates
6:30 P.M.	Dinner-Theatre ***Starring Pat Paulson in "Last of the Red Hot Lovers"***

Saturday, April 28, 1973

8:15 A.M.	Breakfast*
9:15 A.M.	***"The Drug Galaxy"***, Mrs. Marguerite Robinson, Food & Drug Administration
10:15 A.M.	***"Why Did I Take The Certification Examination?"***, Mrs. Jeanne Green, CMA, AAMA Trustee
12:30 P.M.	Awards Luncheon*
2:30 P.M.	Flight Surgeon, United Airlines
3:45 P.M.	***"The Female's Role in Medicine–Yesterday, Today and Tomorrow"***, Dr. Nora K. Miller, Dr. Libuse Bliss, Dr. Victoire Lespinasse
7:00 P.M.	Installation Banquet* ***"The Impact of Noise on People and Environment"***, Dr. Michael Clinch and Mr. Harold Wakely

Sunday, April 29, 1973

9:00 A.M.	Breakfast* ***"Tell It Like It Is"***, Mrs. Louis Sevall
11:00 A.M.	Council Meeting

**Meals included in registration fee.*

NAME_____

ADDRESS_____

COUNTY_____ GUEST_____ MEMBER_____

EMPLOYER_____

EMPLOYER'S ADDRESS_____

Number of General Registrations_____@ $25.00 Total_____

Number of Dinner-Theatre Tickets_____@ $10.00 Total_____

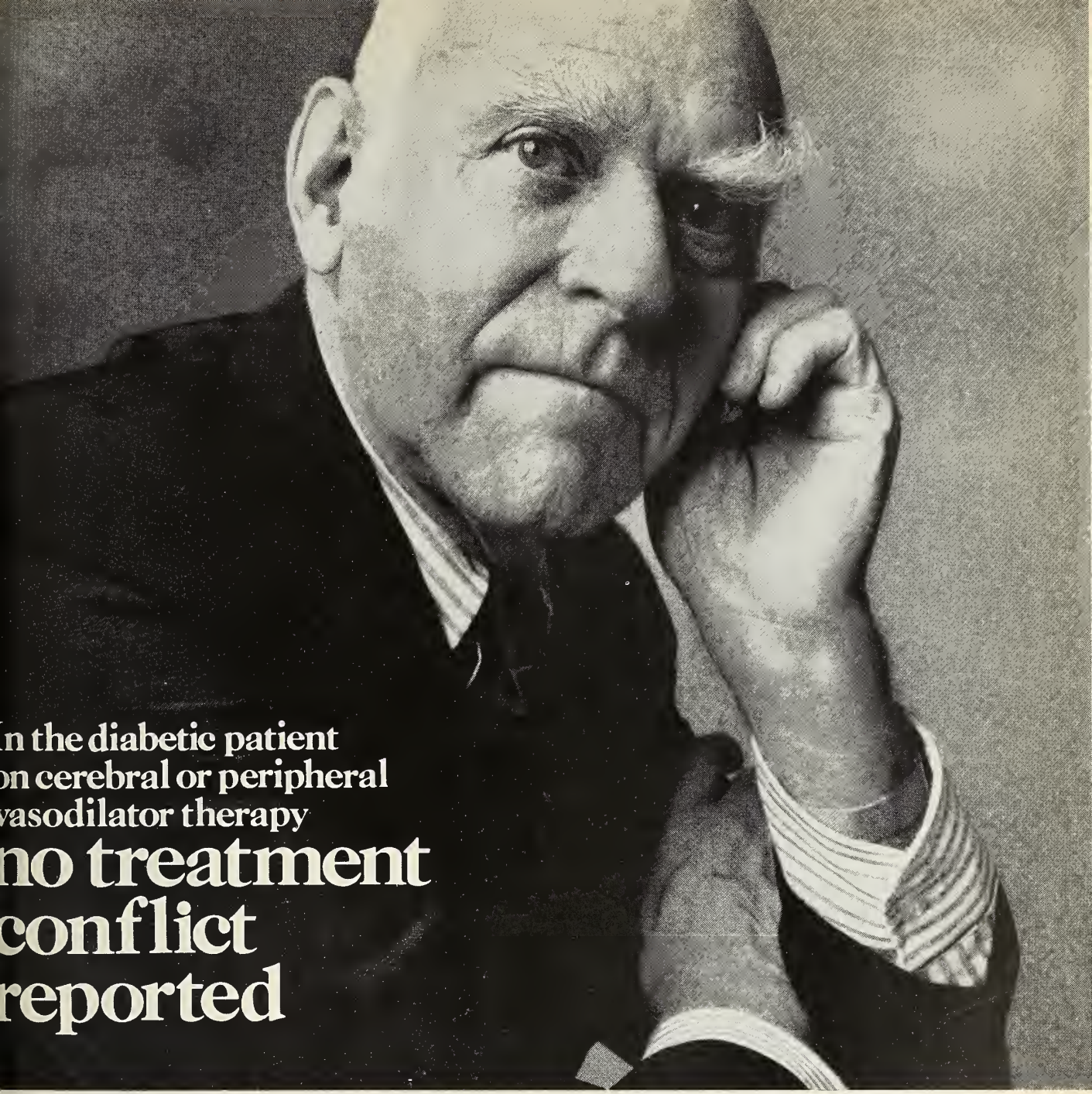
Number of extra Banquet Tickets_____@ $11.50 Total_____

TOTAL AMOUNT ENCLOSED_____

REGISTRATION DEADLINE: APRIL 16, 1973

Please mail form and fee, payable to ILLINOIS SOCIETY CONVENTION FUND to: ***Miss Pat Freund, Registration Chairman, 107 Oak Street, Elgin, IL 60120.***

HOTEL RESERVATIONS MUST BE RECEIVED BY PHEASANT RUN LODGE AT LEAST 30 DAYS PRIOR TO CONVENTION



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- no interference with diabetic control . . . does not alter carbohydrate metabolism.[1]
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There are no known contraindications in recommended oral doses other than it should not be given in the presence of frank arterial bleeding or immediately postpartum.

INDICATIONS: Based on a review of this drug by the National Academy of Sciences–National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

DOSAGE AND ADMINISTRATION: 10 to 20 mg. three or four times daily.

CONTRAINDICATIONS AND CAUTIONS: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

ADVERSE REACTIONS: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

SUPPLIED:
Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose
20 mg.—bottles of 100, 500 and Unit Dose

OMPOSITION: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

REFERENCE: 1. Samuels, S. S., and Shaftel, H. E.: J. Indiana Med. Ass. *54*:1021-1023 (July) 1961.

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New Insurance Program For ISMS Members

To: The ISMS Membership
Subject: Professional Liability Insurance

In the February 12, "Action Report," all ISMS members received the news that the Board of Trustees has approved a new society-sponsored professional liability insurance program. The Hartford Insurance Group, one of the largest insurance companies in the world, will underwrite the coverage. The new program will be effective June 1, 1973, so as to provide continuous coverage for those members whose insurance under the present program will terminate on May 31, 1973.

We at Johnson & Higgins appreciate the action of the board in appointing our firm to manage and administer the new program. Our relationship with ISMS dates back to 1971 when we began a series of meetings on the professional liability insurance problem with the officers and staff of your society. These meetings resulted in our receiving an appointment from the trustees in May, 1972, to investigate the professional liability situation in Illinois.

Our seven month study culminated in January, 1973, when we submitted a detailed report on professional liability insurance in Illinois and a proposal of the Hartford Insurance Group for a new program. The report and proposal were presented in open competition with several other brokers and insurance companies.

It is important to note that the new society-sponsored program does not merely replace the existing program by substituting one insurance carrier's name and forms for another. Instead, the program involves an entirely new concept of professional liability insurance for Illinois physicians. It is a concept that Johnson & Higgins developed successfully with the Hartford, in 1970, for physicians in southern California, an area that up to then had been plagued by a deteriorating professional liability situation.

We are confident that you will like what you see. The Hartford Insurance Gorup has been sensitive to the concerns of the ISMS and the needs for full financial disclosure to the membership, investment income credits, low administrative expenses and physician involvement. And the insurance company has responded in a positive manner.

In a few weeks each ISMS member will receive an individual enrollment kit with complete details of the program. You will find that the premium rates compete very favorably with those of the terminating Employers' Fire Insurance Company plan and those of other insurance companies offering professional liability coverage in Illinois. The rates are especially competitive in light of the many other features of the new program.

Johnson & Higgins has a separate staff of counsellors and administrative personnel in our Chicago office whose sole function is the ISMS professional liability program. Counsellors are available immediately to meet with county or branch medical societies, hospital staffs, specialty groups, etc., to explain the program. Representatives of such groups can arrange a meeting by completing and mailing the coupon below. In addition, individual physicians who desire information can obtain it by mailing the coupon or by contacting Perry Smithers at the ISMS offices.

We recognize the critical importance of sound professional liability insurance to organized medicine in Illinois. Johnson & Higgins is dedicated toward working with ISMS and the insurance company in a three-way partnership to attain that objective. We look forward to a long-term relationship with each society member.

Johnson & Higgins of Illinois, Inc.
101 S. Wacker Drive
Chicago, Ill. 60606

TO: Johnson & Higgins

ISMS Professional Liability Insurance
101 South Wacker Drive
Chicago, IL 60606 (312) 236-3491

Check Appropriate Box

☐ We would like a representative to meet with our group to explain the new professional liability program.
☐ I need personal information about the plan.

(name)

(organization)

(address)

(phone number)



What goes on

a guide to continuing education

March 21-23–Illinois Association for Maternal and Child Health

The 17th Annual Congress

The program is being planned around the theme "Maternal and Child Health, New Emphasis and Direction." Seminars, lecture-forum, presentations and roundtables will cover many disciplines involved in maternal and child care. There will be a visual aids room and scheduled showing of films.

Peoria Hilton, Peoria, Illinois

March 26-29–University of Illinois

Course in Neurotology

Abraham Lincoln School of Medicine, the University of Illinois, will conduct a continuing education course in Neurotology. This four day intensive course will offer a didactic and practical review of clinical neurotology, under the direction of Nicholas Torok, M.D. It will include basic vestibular physiology and pathophysiology and commonly used testing methods applied in functional examination of the vestibular organ.

Various forms of caloric testing procedures will be demonstrated using nystagmography, reading and evaluation of the test results, particularly the nystagmogram and correlation with audiometric and neurologic findings, final neurotological diagnosis, management and treatment. Patients will be tested by participants and the history, symptoms and test results will be discussed in informal conferences.

Contact: Department of Otolaryngology, University of Illinois, 1855 West Taylor Street, Chicago

Eye and Ear Infirmary, University of Illinois, Chicago

March 28-29–The Cleveland Clinic Educational Foundation

New Methods of Treatment in Neurology

A postgraduate course in Neurology. Participating in the course will be several guest speakers, such as Simon Horenstein, M.D., Russell Snyder, M.D., and B. Joe Wilder, M.D.

Contact: The Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland, OH 44106

Bunts Auditorium, Cleveland, OH

April 4–Martha Washington Hospital

Skin Signs of Diabetes–Lecture

This lecture begins at 9:00 a.m. and will be given by Dr. Silas Walk, dermatologist.

Contact: Fernando Lopez-Fernandez, M.D., Medical Director, Chairman, Continuing Medical Education Committee, Martha Washington Hospital, 4055 N. Western Avenue, Chicago, IL 60618

Martha Washington Hospital, Chicago

April 4-6–Illinois Public Health Association

33rd Annual Meeting

The three-day meeting will be attended by public health workers in Illinois representing medical health officers, public health and school nurses, sanitarians, health educators, dentists, public health administrators, clerical personnel and representatives of voluntary health agencies.

The theme of this meeting will be "How mental is health?"

The hope of this meeting is that it will promote and encourage co-operation between various health agencies and disciplines and re-establish a common interest in a common problem.

Contact: Illinois Public Health Association, 5635 State Road, Oaklawn, IL 60459

Arlington Park Towers, Arlington Heights, IL.

April 11–University of Chicago

Advances in Neurological Diagnosis and Treatment

Part of the Frontiers of Medicine Series, presented by the University of Chicago, program will emphasize practical considerations applicable in both hospital and office in the diagnosis and management of headache and facial pain; Parkinson's disease; acute head injury; convulsive disorders and cancer of the nervous system.

Registration: $15

Contact: Frontiers of Medicine, University of Chicago, BH Box 451, 950 E. 59th St., Chicago, IL 60637

Albert Merritt Billings Hospital, Chicago

April 16-18–The Tri State Hospital Assembly

Great Lakes Health Congress

The congress will include a series of general assemblies, educational conferences and seminars, all of which are directed towards keeping abreast of latest techniques and developing improved methods of operating hospitals and nursing homes.

Contact: Sam S. King, Herbert M. Kraus & Co., 75 E. Wacker Drive, Chicago, IL 60601

McCormick Place on the Lake, Chicago

April 19-21–University of Kentucky, College of Medicine

Workshop and Conference on Pulmonary Thromboembolism

An outstanding internationally known guest faculty, as well as faculty of the University of Kentucky, has been assembled to provide surgeons and internists with a helpful review and an opportunity to examine newer techniques and developments.

Registration: Conference $150; Workshop $100
Contact: Frank R. Lemon, M.D., Associate Dean for Continuing Education, College of Medicine, University of Kentucky, Lexington, Kentucky 40506
U.K. Medicine Center, Lexington, Kentucky

April 26-27–IIT Research Institute

Workshop on Scanning Electron Microscopy in Pathology and Sixth Annual Scanning Electron Microscope Symposium

In announcing the Workshop, Om Johari, Director of Annual SEM Symposia, said "while the applications of scanning electron microscopy in biological sciences are increasing at an extremely rapid rate, its full potential in pathology are yet to be exploited. The Workshop will provide a forum for pathologists and electron microscopists to discuss work currently in progress, evaluate it in terms of their own work and better prepare themselves for applying scanning electron microscopy in their activity."
Contact: Dr. Om Johari, Director, Annual SEM Symposia, IIT Research Institute, 10 W. 35th St., Chicago, IL 60616
IIT Research Institute, Chicago

Pacemaker Experiences . . .

(Continued from page 245)

the batteries become completely depleted. We have been impressed with the marked functional improvement in these individuals and with the exception of four deaths, one due to cardiovascular complications, two resulted from congestive heart failure, one caused by granulomatous myocarditis, and one case with advanced cardiac disease with marked functional impairment, the results have been excellent. In the selection of cases for the use of pacemakers, the presence of Adams-Stokes syndrome and the potential functional capacity of the heart should be the two major criteria; advanced age, in itself, is not a contraindication. Even symptoms attributed to cerebral ateriosclerosis have been markedly improved in some people following the institution of permanent pacing.** ◄

***Special recognition is to be given James E. Bitter, M.D., my surgical associate, who has inserted all the transvenous electrodes as well as implanted all the permanent pulse generators.*

References

1. Diseases of the Heart, C. K. Friedburg, page 595, W. B. Saunders Co., 3rd Edition.
2. "Diseases of the Heart and Blood Vessels, Nomenclature and Criteria for Diagnosis," The Criteria Committee of the New York Heart Association, pp. 112-113, Little, Brown & Co., 6th Edition, 1964.

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Guest Editorial

The Breathing Hot Line

Mrs. M. was anxious and concerned because her husband's breathing problem had become so severe that even simple chores left him weak for hours.

Searching for guidance and help, she ultimately called the Chicago Lung Association which she had learned about through a Christmas Seal mailing describing its respiratory disease programs. She was given the names of several physicians in her area to whom she could turn as well as free literature to help her better understand her husband's condition.

Because finding help for people like Mrs. M's husband has been so difficult in the past, the Chicago Lung Association (formerly The Tuberculosis Institute of Chicago and Cook County) started a special referral service on respiratory disease diagnostic and treatment facilities.

Now, simply by calling one phone number, **(312) 243-2000,** a Chicago area resident can get the name of a physician, a list of hospital affiliated clinics with RD diagnostic and treatment facilities as well as firms which supply respirators, oxygen and other specialized equipment required by RD victims.

This list of medical resources and facilities which is kept up to date by continual checking was compiled by special surveys of physicians holding membership in the American College of Chest Physicians, American Thoracic Society, College of Internal Medicine and others practicing in this field.

Because many RD patients like Mrs. M.'s husband need mechanical breathing aids for home use a list of firms which rent and sell inhalation therapy equipment, emergency oxygen, ultrasonic nebulizers and air purifiers is also kept up to date for referrals as needed. Information on industrial masks, medical identification bracelets and other aids for respiratory disease patients is provided on request.

Christmas Seals provide the funds for this service as part of Chicago Lung Association's program to improve the respiratory health of all citizens. To take advantage of this RD referral service you may call 243-2000 or write to Chicago Lung Association, 1440 W. Washington, Chicago, 60607.



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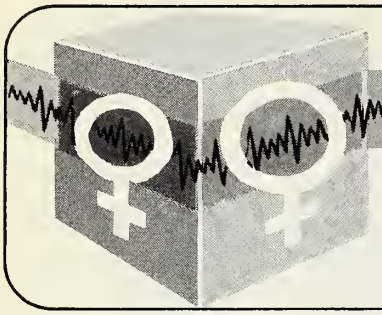
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SPECIALTY REVIEW IN DERMATOLOGY April 30
SPECIALTY REVIEW IN OBSTETRICS & GYNECOLOGY, April 30
DISEASES OF ESOPHAGUS, STOMACH & DUODENUM, April 5
SURGERY OF GASTROINTESTINAL TRACT, Four Days, April 9
PROCTOSCOPY, SIGMOIDOSCOPY & FIBEROPTIC COLONOSCOPY, Three Days, April 25
ADVANCES IN SURGERY, One Week, May 7
SURGERY OF TRAUMA, Four Days, May 14
BASIC OBSTETRICS, One Week, April 9
BASIC GYNECOLOGY, One Week, April 2
COMMON GENETIC DISEASES, One Week, May 7
FAMILY PRACTICE REVIEW, One Week, May 14
INTERMEDIATE ELECTROCARDIOGRAPHY, Two Days, May 10
ADVANCED CARDIOLOGY, One Week, April 30
ADVANCES IN MEDICINE, One Week, May 7
REFRESHER COURSE IN RADIATION SCIENCE, One Week, May 21
STATE & NATIONAL BOARD REVIEW, Basic, April 29, Clinical May 7

Information concerning numerous other continuation courses available upon request.

Address:
REGISTRAR, 707 South Wood Street,
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pulse... of the doctor's wife

Mrs. Robert Hart, Editor

From the President's Desk...

You are invited to attend the convention and "get to know us." The officers and chairmen have traveled from Atlantic City to San Francisco for National Conventions representing Illinois skillfully, and also to states in between for their scheduled conferences and sessions, and to state conventions of surrounding states. The intent was to glean the latest up-to-the-minute changes in our mores, culture, needs, and ideals, plus to study and package for you their year's accomplishments.

Our aims are to jointly critique and evaluate the volumes of information and be able to transact and motivate the needs of the counties, thereby sharing in our common goals. This will insure that we will continue to grow and serve our comunities, fulfilling one of the purposes of our auxiliary.

Remember, convention time is time to "get to know one another better," so see you at the Conrad Hilton, March 25-28.

Mrs. August Martinucci
President

Officers Slate Submitted

The Nominating Committee composed of Mrs. David Kweder, Chairman, Mrs. Gaetano Buttice, Mrs. Ralph Davis, Mrs. John McLaughlin, and Mrs. Fred White announced the slate of officers for 1973-74 as follows:

President-elect:
Mrs. Franklin D. Yoder, Springfield
Vice-President—Membership:
Mrs. Thomas Glatter, Rockford
Vice-President—Community Health:
Mrs. Joseph Shanks, Chicago
Vice-President—Program:
Mrs. Ralph White, Oak Park
Recording Secretary:
Mrs. Bernard Baalman, Hardin
Treasurer:
Mrs. William Hodges, Kankakee
Directors:
Mrs. August Martinucci, Joliet
Mrs. Sherman Arnold, Flossmoor
Mrs. Newton DuPuy, Quincy

This slate will be voted on at the March Convention. Mrs. Robert Hartman will be the new President.

Is She Sure She's Wanted?

For a time I taught Sunday school. But it wasn't my idea. I was asked. I also did my stint with the PTA. But again, I didn't volunteer. I was made to feel that my help was needed.

I worked for Girl Scouts, Boy Scouts, the Heart Association, the Art Academy, Hawaii Geographic Society. And three were others. Always I was invited.

I wouldn't have volunteered for any of them. Not because of opposition to helping. Not at all. I think I subconsciously felt that it is pushy to volunteer and aparently many people feel this way. It is an unusual person who spontaneously seeks a job, or even membership. Even in the auxiliary, our special organization, there is hesitation. We need encouragement, an invitation. There are many different kinds of invitations. They vary all the way from the impersonal, mimeographed meeting notices, usually with a dues listing, to the friendly offer to drop by and accompany the prospect to a meeting. The latter personal approach is the more effective beginning. It serves as the start for a gradual build-up that can lead to interest and membership.

Now for the follow-up to get that new auxiliary member. Don't stop with one contact. Bring her again and again. Loan her your copy of

MD's Wife. Tell her about your program and projects. Give her reasons for your enthusiasm. Make her feel needed and wanted. And when she is ready, ask her to do a job, perhaps even that of cultivating another prospective member.

There is no substitute for individual attention in attracting new members. Jefferson County, in Kentucky, recently decided to give membership top priority. The president challenged the individual members and the appropriate committees. With wholehearted cooperation, the membership committee put in extra hours, planning, writing and calling prospective members. The hospitality committee provided "aloha" at meetings and members encouraged friends to join. Officers arrived at meetings early to greet new and returned members. The program committee planned meetings with entertainment as well as education. The president even took time to send individually handwritten notes to prospective and new members. They wanted the newcomer to the medical world in Jefferson County to join the auxiliary, attend meetings and know that she was needed. They wanted the member who hasn't been active for several years to come to their meetings; they wanted her to feel important. They wanted this so much that their sincere friendliness showed and they've had a healthy jump in membership.

Their newsletter says, "We are all more involved, and this involvement means more interest. We have become electric . . . we are beginning to discover that CARING ABOUT OTHER MDS' WIVES pays off in the fellowship of woman-power." It worked for them; they won a national membership award. And it can work for the rest of us.

Mrs. Howard Liljestrand
WA/AMA, Chairman, Membership Committee

Membership Movement in Full Swing

Auxiliaries throughout the state have been emphasizing recruitment of new members this past year, hoping to meet the pre-convention goal of 4,000 members, and 50 organized auxiliaries. Statistics as of July, 1972, revealed:

10,600—Illinois Physician-Members
Illinois State Medical Society
2,894—Woman's Auxiliary Members
63—Members-at-Large
36—Counties Organized

During 1973, membership will continue to be one of the foremost goals and all auxiliaries are urged to:

MOTIVATE CURRENT MEMBERSHIP

Make membership aware of all resources available—publications, films, package programs, and best of all, local community resources —individuals, organizations, institutions.

ORGANIZE NEW AUXILIARIES

Our Organization is unique to doctors' wives—our opportunity is to promote our husband's concern, improve his image, and that of medicine everywhere.

VITALIZE PRESENT AUXILIARIES

Select a goal difficult enough to require hard work, but not unattainable. Vitalize by working with other organizations in efforts of community concern.

ENTHUSE AND INVOLVE MEMBERSHIP

Plan a program of variety and flexibility aimed at stimulation, involvement, accomplishment, and FUN!



Mrs. Clifford Nyman, president of the Woman's Auxiliary of the Kane County Medical Society, presents a check to medical student William Dwyer of Elgin, a participant in a 10-week educational program at Delnor Hospital (St. Charles). Pictured from left are: Rich Davito, medical student; Mrs. Nyman; Mrs. Charles Whitney, Auxiliary Vice-President; Dwyer, and Dr. James Pritchard, Coordinator of the Student Program at Delnor and Chief Pathologist. "Our Auxiliary is happy to provide this kind of service because of the benefit to students," says Mrs. Nyman. "Each year the Auxiliary holds fund raising events with proceeds going to various educational programs." Next fund raising event," says Mrs. Whitney, "will be a style show at Dunham Woods, April 2, 1973."

Obituaries

Benson, Arnold, died at the age of 80 on December 21. Dr. Benson practiced medicine in Aurora for 40 years. He was a graduate from Northwestern Medical School in 1919 and was public health officer in Aurora for several years. He was a former president of the Kane County Medical Society.

***Bremner, James X.,** Evanston, died November 19, at the age of 66. He was a member of the faculty of Loyola University Stritch School of Medicine and had been on the staff of St. Francis Hospital in Evanston for 40 years.

Brown, Joshua, M., died December 30, 1972, at the age of 87.

***Edwards, Clarence O.,** Libertyville, died at the age of 74. He practiced in Libertyville for more than 40 years and was past president of the medical staff at Condell Memorial Hospital. He was also a past president of the Lake County Medical Society.

***Ferguson, Lloyd Allen,** died January 1, at the age of 40. He was associate professor in the department of medicine and assistant dean of students in the division of biological sciences, the Pritzker School of Medicine at the University of Chicago.

Gable, Clyde A., Chicago, died at the age of 58. He had been a psychiatrist at the Danville Veterans Administration Hospital.

Hupfear, Daniel A., McHenry, died December 19. He was an osteopathic physician in Chicago and McHenry for a period of 45 years.

***Johnson, Arive T.,** Florida, died at the age of 66. He was a graduate of the University of Chicago, Rush Medical College. Dr. Johnson limited his practice to internal medicine, in Rockford, for 35 years.

***Kobak, Alfred J.,** Glencoe, 74, died December 27, 1972. Prior to his retirement in 1968, he was chairman of the Department of Obstetrics and Gynecology at Cook County Hospital.

***Mohr, George D.,** Pickneyville, died at the age of 57. He received his medical degree from St. Louis University.

***Toigo, Angelo,** Pennsylvania, died at the age of 46. He was formerly from Chicago where he received his medical degree at Northwestern University.

***Wagner, Harold,** Chicago, died January 19.

**Indicates member of ISMS.*
***Indicates member of ISMS and Fifty-Year Club.*

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Abstracts of Board Actions

(Continued from page 220)

INA-ISMS Joint Practice Committee

The Board approved a recommendation of the INA-ISMS Joint Practice Committee that:

1. There should be no changes in the medical and nursing practice acts that pertain to the scope of practice, and

2. The moratorium on licensure for new groups of health care personnel be continued at least through 1974, or until any proposed changes reflect study and support that will expand and clarify scopes of practice which improve the quality and accessibility of health care, as well as strengthen professional roles.

Nutrition Week

ISMS will join other interested organizations in petitioning the Governor to declare March 4-10 "Nutrition Week" in Illinois.

SIU School of Medicine Appropriation

The Board ratified an Executive Committee position supporting the upgrading of medical education and retention of physicians in Illinois through the judicious use of state funds and a request to the Board of Higher Education that sufficient funds be provided for all medical school programs to enable them to maintain their high degree of quality education. The action followed a request from Southern Illinois University that ISMS support its proposed 1973 budget. The Executive Committee said it was not in a position to evaluate specific budgetary needs of any medical school.

Communications Program on PSRO

In view of the impact that Professional Standards Review Organizations will have on the practice of medicine, ISMS will undertake a special PSRO communications program in 1973. Included will be a special PSRO conference at the annual meeting; establishment of a speakers bureau for county medical societies; regional conferences throughout the state; publication of an informational brochure on PSRO and ongoing coverage of PSRO in all ISMS publications. Anticipated cost of the program is $7,500, which will be requested from the Educational & Scientific Foundation.

Areawide Hospital Emergency Services and Ambulance Standards

Each trustee will discuss with physicians in his district the areawide hospital emergency service plan scheduled to be operational by July 1. Comments and criticisms will be forwarded to ISMS headquarters for use by an ad hoc Committee on Emergency and Disaster Care in meeting with the program director, Dr. David Boyd. Board members have complained that at the regional meetings, set up to explain the new program, there has been little opportunity for physician input, as the program is already organized.

The Board endorsed the following recommendations of the ad hoc committee:

1. Oppose any legislation calling for standards which threaten existing ambulance service in Illinois or which would substitute the Trauma System for local ambulance services;

2. Support activities that would make the Trauma System a source of training, direction and support for existing services;

3. Encourage utilization of all local emergency faciilties (such as civil defense, fire departments and other volunteers);

4. Encourage adoption of the Medical Self Help Training course as a minimum training requirement for ambulance personnel;

5. Encourage ambulance operators to voluntarily upgrade training and equipment;

6. Work to extend the Good Samaritan concept to the emergency room.

In conjunction with the training of emergency medical technicians by the Illinois Department of Public Health's Division of Emergency Medical Services and Highway Safety, the Board adopted the ad hoc committee's recommendation's as follows:

1. To require all medical procedure training (such as intubation, aspiration, IV, ECG) be conducted by physicians or nurses specially training for this purpose under the direction of physicians.

2. That all medically oriented curriculum materials be reviewed continuously by a committee of physicians knowledgeable in the care of the trauma victim or emergency, non-ambulatory patient—this concern to be related to IDPH by the society's representative to the Trauma System.

Immunity for HASP Members

ISMS will not seek legislation to protect HASP committee members from liability since the newly-enacted H.R. 1 provides such immunity under its PSRO section.

Constitution and Bylaws

A recommendation that the bylaws be amended to provide for a vice-chairman of the Board of Trustees was referred to the Executive Committee. The recommendation also provides for the vice-chairman to be a member of the Executive Committee. Proposals to amend the district organization sections of the bylaws and proposals to change the duties of the trustees are being disseminated to members of the Board for their consideration and possible future action.

Professional Liability

An Insurance Committee recommendation that ISMS contract with Johnson & Higgins of Illinois, Inc., to provide malpractice insurance for ISMS members was accepted, subject to further negotiation and clarification of future participation requirements established by the underwriter, Hartford Fire Insurance Co. Final action on the proposal is to be taken by the Executive Committee. Replacement of the program is necessary because the present carrier, Employers-Commercial Union, has ceased being a major insurer of professional liability insurance and has dropped the Illinois coverage, similar to action recently taken in Florida.

In a related action, the Board approved a special $5,000 allocation to the Medical-Legal Council to establish a pilot arbitration program in conjunction with malpractice claims. Guidelines for the project were previously approved by the Board. The action is subject to agreement on final details with the co-sponsoring organizations, the Illinois Hospital Association and Chicago Hospital Council. The services of the American Arbitration Association will be utilized. ISMS will make space, telephone and part-time secretarial service available as needed. Expenses for the project will be shared equally among the three organizations.

Resolutions on Health Insurance and Physician's Fees

The Board endorsed the concept of a pilot program for Wayne and Edwards counties under which the Illinois Department of Public Aid would purchase comprehensive health insurance coverage for recipients. Details will be presented to the House of Delegates in a resolution to be introduced by the Wayne County Medical Society. The plan would include provision for deductibles and co-payments by welfare patients.

Also endorsed was a resolution, prepared by the Council on Economics and Peer Review, urging ISMS to take a strong position supporting payment for assistants at surgery under all health insurance policies and to identify those carriers refusing to cooperate. The resolution also calls for the introduction of appropriate legislation to make such coverage mandatory.

In acting upon a report of the Council on Mental Health and Addiction, the Board authorized a study of the legal implications of legislation which would require all insurance policies to offer mental health coverage as mandatory options (purchaser would be required to specifically decline; otherwise coverage would prevail). In completing these actions, the Council on Economics and Peer Review was directed to draft proposed minimum standards for health insurance coverage and report back to the Board at its next meeting.

Social Security Benefits and IDPA Allotments

The Board agreed to a recommendation that ISMS protest the deduction of any portion of the recent Social Security benefit increase from the Illinois Department of Public Aid's checks to welfare recipients.

Financial Aid to Medical Education

The Board will seek the help of appropriate Illinois congressmen in restoring health profession funds affecting the education of primary care physicians. The funds are threatened by proposed cuts in the HEW budget.

In a related action, the Board was informed that the Country Life Insurance Co. had offered a line of credit to the Student Loan Fund Board to stabilize the fund from which loans are made to medical students. The fund, jointly sponsored by ISMS and the Illinois Agricultural Association, is experiencing a shortage of working funds due to the heavy demands for assistance. Thirty-one students under the program were accepted for enrollment by the University of Illinois for next fall. The Board referred the proposal to its Finance Committee for action.

Continuing Medical Education Accreditation

In order to accomplish accreditation of continuing medical education activities, the Council on Education and Manpower has developed guidelines for surveying educational programs of hospitals and other agencies. These have been approved in principle by the Board. The Illinois Council on Continuing Medical Education will be responsible for details of the surveys. However, the state medical society is responsible for final decisions on accredited status of any program. Broad operational procedures to enable cooperative ISMS-ICCME activity were approved, subject to final fiscal arrangements.

Involvement of Young Physicians

The Board approved a recommendation that ISMS explore through the Council of Medical School Deans the feasibility of a governmental affairs program for senior students and the faculty of Illinois medical schools.

Proposals for Legislation

Acting on the report of the Council on Governmental Affairs, the following legislative proposals were approved:

1. To alter the age of consent to allow adolescents 16 years of age and over to be treated for mental illness, with the physician deciding whether or not the adolescent's parents shall be informed. The Council on Mental Health and Addiction supports this proposal.

2. To include acupuncture as a branch of medicine under the Illinois Medical Practice Act and limit its use by anyone not licensed to practice medicine and surgery in all its branches to experiments in medical schools.

3. Support for S.B. 003, lead poisoning substances control act.

Auxiliary LEGS PROGRAM

The Board approved establishment of the AMA Auxiliary's LEGS program-Legislative Effort Groups System-and offered all possible support. The proposal calls for the appointment of at least 10 women in each congressional district to generate phone calls on legislative issues.

Communicable Diseases

Legislation has been prepared by the Illinois Department of Public Health to amend the Communicable Disease Act by striking reference to specific communicable diseases. The ISMS Council on Environmental and Community Health recommended support of this position in order to give the health department more flexibility. The Board agreed and directed its Governmental Affairs Division to help with implementing the legislation.

The Board also agreed that no statement on the pre-marital examination form should be required to indicate that a culture for gonorrhea has been taken.

Diabetes Screening

The Board endorsed plans of the Illinois Society for the Prevention of Blindness to incorporate free testing for diabetes mellitus along with glaucoma screening beginning early in 1973.

Child Abuse Law

Upon recommendation of the Pediatric Coordinating Council, on which ISMS is represented, the Board re-affirmed support for the reporting methods called for in the present Child Abuse Act and opposed changes to include mandatory reporting of child abuse incidents to the police as well as the Department of Children and Family Services. The present reporting system is to be supported officially.

Alcoholism Curriculum

On recommendation of the Council on Mental Health and Addiction, the Board will inform the Council of Medical School Deans that ISMS favors inclusion of alcoholism control in the medical school curriculum. The Mental Health Council was also authorized to act as a catalyst to get interested organizations together to review the Uniform Alcoholism and Treatment Act.

Appointed to HCCI

Dr. Allan Goslin, Streator, has been appointed ISMS representative to the Health Careers Council of Illinois.

Annual Meeting

A special reference committee will be appointed to conduct an open forum during the annual meeting to allow individual members of ISMS to bring to the attention of the House of Delegates any matter that concerns them. Reference Committee hearings will be at 7:00 p.m. Sunday, March 25, in various locations in the Conrad Hilton Hotel, where the ISMS annual meeting and Midwest Clinical Conference will continue through March 28. ◄

Physician Recruitment Program

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program. This is a free service to all physicians.

Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 360 North Michigan Ave., Chicago, 60601.

ALBION: General Practitioner. Population 1,800, trade area 13,000 with only 4 physiicans in area. Office facilities, financial assistance available. Rural setting, county seat town; expanding economy, hospitals nearby. City park, swimming pool, tennis courts, etc. Unit school district, Community College 15 minutes. Contact: Don Broster, Citizens National Bank, Albion, 62806, 618-445-2344. (4)

AVON: General Practitioner. Population 1,000, trade area 3,500 to 4,000. Rural practice. Twenty-four bed hospital in town. Office facilities available. Recreational facilities nearby. Excellent area in which to practice and raise a family. Contact: Fred L. Janes, Avon, 61415, 309-465-3883. (4)

BUNKER HILL: Population 2,000; friendly community. Opening for general practitioner. Five hospitals within a 30 mile area. No recreational facilities, but we need you. Surrounding country practice. Contact: Frances S. Stadelman, 110 W. Warren St., Bunker Hill, 62014, 618-585-4565. (5)

BUSHNELL: General Practitioner. Where a doctor can have a family life. Population 3,800. Literally minutes from stocked lakes, water sports. Good hunting. Your dream home costs less. State University close by. Our doctor did Europe all September. Visit there, come home here. Contact: Jack Gordon, Box 150, Bushnell, 61422. 309-772-3141. (4)

CARBONDALE: 25 man multi-specialty in southern Illinois needs Internists, Dermatologist, OB-GYN, Family Practitioners. Generous salary and fringe benefits, early partnership. New, modern building. Developing medical school. Contact: Wayne Given, P.O. Box 1030. Carbondale. 618-549-5311. (4)

CARLINVILLE: G.P., I.M., Ped., OB-GYN. Population 5,700. Mid-way between St. Louis and Springfield. Serves 30-mile trading area of 50,000 population. Newly built physicians building adjacent to hospital. Modern office space for doctors. Modern 68-bed hospital fully equipped and staffed. Opportunity for building large practice. We need doctors. Contact: James Rives, Carlinville Area Hospital, Carlinville, 217-854-3141. (7)

CARROLLTON: You can't match or beat the medical opportunities in Greene County, for a family Physician. Group practice being set-up in a new office building near hospital. For further information write or phone: Drs. Caselton or Wilson or Ray Shoemaker, Carrollton, 62016, 217-942-6946. (4)

CANTON: Urologist and Pediatrician needed by 12-man multi-specialty group. Aggressive city of 15,000 thirty minutes from Peoria. Excellent starting salary leading to full share in corporation. Tax savings and pension plan. Many recreational activities in area. Contact: S. C. Johnson, Coleman Clinic Limited, 175 S. Main St., Canton, 61520, 309-647-0201. (5)

CASEY: G.P. wanted to join Medical Center Staff; lab, X-ray, P.T., remote EKG, IPPB, 2 Observ. Rooms, 2 Emerg. Rooms, 24 hr. Emerg. Ser., call every 4th wkend, 1 wk. day, pleasant community, good schools, numerous churches, exceptional recreational facilities, golf course, country club, airport. Contact: Howard G. Johnson, Casey Medical Center, Box 427, Casey, 62420, 217-932-4061. (4)

CHADWICK: General Practitioner. Population 600. Office faciilties available. Former physician left practice of twelve years to retire to West Coast. Five minutes from country club and twenty minutes from Mississippi River. Contact: LeRoy Foltz, 329 Marion, Chadwick, 61014, 815-684-5128. (4)

CHAMPAIGN-URBANA: Opportunities for Neurologist, Nephrologist, Internists, and Orthopedist in prospering 30-man group. One-third of doctors under 35. Affluent Big-10 town of 90,000 with top schools and real cultural/recreational attributes. Full Associateship after 18 months on excellent guarantee. Write or call collect: Joseph A. Zalar, Jr., M.D., Christie Clinic, Champaign, 61820, 217-384-1240. (4)

COAL CITY: General Practitioner. Growing community, with trade area of 15,000, offers to a physician a completely equipped office. Free for six months. Only one hour from Chicago, three hospitals nearby, and great recreational facilities for leisure. Contact: John Nicoletti, Coal City, 60416, 815-643-8608. (4)

DE KALB: 33,000 Population. University town. Good schools—all religious denominations. Complete office facilities—X-ray & Lab.; with 6 physicians—including OB-GYN, General Surgeon, Family Practitioners. Need Internist & Family Practitioner. Financial assistance available. Contact Gordon Graham, 901 N. First, De Kalb, 60115, 815-756-6611. (4)

EFFINGHAM: Service area 60,000—Central Illinois at intersection of I-57 and I-70. G.P.s, OB-GYN, Urology, Orthopedic Surgeon, Internal Medicine. Clinic or solo practice. Progressive community. Contact: Don Kabbes, 503 North Maple Street, Effingham, 62401, 217-342-2121. (4)

EVANSVILLE: General Practitioner. Population 1,000 with a large rural area. We are 15 minutes away from any one of three new hospitals. We stand ready to build to one or two doctors' needs. Also, we have financial assistance available. Contact: Jim Biethman, Box 144, Evansville, 62242, 618-853-2629. (4)

FAIRFIELD: General Practitioners Wanted. Are you bored and want a challenge? Do you want to practice where they don't ask about your diploma, or your specialty? Are you genuinely interested in people and their problems, rather than diseases and cases? If so, come on down to Fairfield and get your feet wet! Write or phone collect: Jerry Vaughan, Box H, Fairfield, Illinois 62837, 618-842-2167. (12)

FLORA: Population 6,000. G.P., Int., OB-GYN, Ortho. Surg., Anesth., Ophth., ENT. Group or solo practice. Nine physicians at present. One hundred miles east of St. Louis on Route 50. Financial assistance available. Excellent school system. Outstanding parks and recreational facilities. Visit at our expense. For an appointment contact: Alvin J. Uebinger, Administrator, Clay County Hospital, P.O. Box 280, Flora, 62839, 618-662-2131. (4)

FREEPORT—population 30,000. Internist & Pediatrician urgently needed to join a corporate 9 man multispecialty group. Established in 1948, new building in 1970. Salary first year. Fringe benefits include $50,000 life policy and retirement plan. For additional information—Freeport Medical Clinic, Ltd., Freeport, 61032, K. H. Shons, Business Manager, 815-233-6131. (9)

GALESBURG: Galesburg Clinic. Population 40,000. Twelve man multispecialty group seeking Ophthalmologist, Orthopedist, Internists, Urologist and Family Physician. New clinic building connected to new hospital. Home of Knox College. Excellent schools, recreational and transportation facilities. A fine opportunity. Contact: L. S. Doyle, Administrator, 320 North Kellogg St., Galesburg, 61401, 309-342-1161. (4)

GENESEO: Ped., OB-GYN, F.P., Orth. Surg., Int. Med. Population 7,000 serving area 30,000 on Interstate 80, 2½ hours from Chicago, 25 miles from Quad-Cities metropolitan areas, over 300,000. Safe, ideal, small city living, 110 bed ultra-modern hospital, excellent schools, recreational facilities. Clement G. McNamara, 210 W. Elk St., Geneseo. Call collect 309-944-6431. (4)

GIBSON CITY: Int., Ped., OB-GYN, F.P. Rural community with hospital facilities. Half-hour to Champaign-Urbana or Bloomington-Normal or two hours to Chicago Loop. Office facilities are available as well as financial assistance if necessary. Contact: Robert E. Jones, Gibson Community Hospital, Gibson City, 60936, 217-784-4251. (4)

HARVARD: General Practitioner. Population, 5,250 with trading area 18,000. Only three physicians. Seventy miles from Chicago, 30 miles from Rockford, 75 miles from Madison and Milwaukee and 8 miles from Lake Geneva-Lake Delavan resort area. Sound economic and growing area. Contact: Mrs. Catherine K. Oost, 58 N. Ayer St., Harvard, 60033, 815-943-5261. (4)

HERRIN: Int., G.P., ENT, Anthes. Population 10,000-trade area 40,000. Near S.I.U., 90 miles to St. Louis. New offices, modern hospital. Beautiful vacationland, all outdoor sports. Financial assistance and salary guaranteed. Call collect Larry Feil 618-942-4710, Herrin Hospital, Herrin, 62948. (9)

ILLINOIS DRUG ABUSE PROGRAM: Full or part-time work in general medicine, psychiatry, research, administration, or any combination of the above. Excellent opportunities for treating all types of chemical dependence, as well as carrying out research on medical and psychiatric aspects of the addiction problem. Also, full or part-time work in special units including alcoholism, severe medical and psychiatric problems, and a discreet operation serving pregnant addicts. Contact: Edward C. Senay, M.D., 5700 S. Lake Shore Drive, Chicago, 60637, 312-955-9800. (4)

LEROY: Population 2,500. Opening due to death of **only** physician. Large practice. Excellent clinical and office facilities. Finanial assistance available. For complete information, contact: Al Provasi, 307 N. Chestnut St., LeRoy, 61752, Phone: Res. 309-062-5101; Bus. 309-962-2721 or Craig Pillatsch, 101 W. Center Ct., LeRoy, 61752, Res. 309-962-7781; Bus. 309-962-7171. (5)

LIBERTYVILLE: Family Physician wanted for medical group of three Family Practitioners. Originated in 1952—Incorporated in 1964—Remodeled in 1972. Fringe benefits: hospitalization, pension, profit sharing, bonus and others. Complete office facilities. Please Contact: Mark H. Fields, Jr., M.D., 716 S. Milwaukee Avenue, Libertyville, 312-362-1390. (4)

LITCHFIELD: F.P., OB-GYN, Ped., Int. Population 7,300, Trade Area 50,000 in 15 mile Radius. New 134 bed hospital. Midway between Springfield and St. Louis, Mo. on I-55. Good schools. Good recreational facilities. Financial assistance can be arranged. Contact: John Short, 723 N. Van Burean, Litchfield, 62056, 217-324-3937. (4)

MACOMB: G.P., Int., Ped. Population 19,000. Home of Western Illinois University. 200 bed open staff hospital. Modern offices available for solo or clinic practice in all specialties. Guarantee plus fringes. No pollution, crime or traffic problems. Rural living with urban culture and recreation. Contact: D. H. Dexter, M.D., Macomb Clinic, Doctors Lane, Macomb, 61455, 309-833-4176. (4)

MARSHALL: General Practitioner. A new medical center now open located 17 miles from Terre Haute where hospital is available. Recreational services include fishing and camping. Another lake is under construction for boating and swimming. Excellent schools. Financial assistance available. Contact: Donald B. Smitley, Cork Medical Center, 410 N. 2nd St., Marshall, 62441, 217-826-2361. (4)

MAYWOOD-DIXON: Population 35,000 and 20,000 respectively. Expanding multispecialty groups, directed towards comprehensive medical care—excellent opportunities for Internist, General Surgeons, Pediatricians, Emergency Room Physicians—now and in the future. Contact: Gene M. Gaertner, M.D., 1908 St. Charles Rd., Maywood, 60153, 312-344-5300. (4)

METROPOLIS: Physicians wanted. F.P., OB-GYN. Complete office facilities. Financial assistance available. Modern, well equipped hospital serving tri-county area in scenic southern Illinois. Contact: Charles Russell, Administrator, Massac Memorial Hospital, Metropolis, 62960, 618-524-2176. (4)

MOMENCE: General Practitioner. Population over 4,000. Opening new health center 14 mi. from Kankakee and 50 mi. from Chicago on Route 1. Office facilities available—some financial assistance available. Contact: Rachel Simpson, 210 N. Dixie, Momence, 815-472-2751; or George Duguay, N. Dixie Hwy., Momence, 815-472-4833. (4)

MONMOUTH: Services area population 30,000. Opening for General Practice and General Surgeon with training in Orthopedics and/or Vascular Surgery. Modern well-equipped hospital—141 beds. Near High-

ways I-74 & I-80. Daily rail to Chicago. Flight service available. Safe place to raise family. Near medical school, liberal arts college. Contact: Roger E. Gurholt, 1000 W. Harlem Ave., Monmouth, 61462, 309-734-3141 X 261. (4)

MONTICELLO, IOWA. Trade area 15,000. Need six or seven additional doctors. Presently served by four physicians, all involved in General or Family practice. Could afford some specialties in combination with General Practice. Financial assistance available. Contact: John Wild, c/o John McDonald Hospital, Monticello, Iowa, 319-465-3511. (4)

MT. CARMEL: General Practitioner. Population 8,100. Medical service center for 25,000 population. Complete medical facilities. Five doctors at present. Rapidly growing area. All recreational and cultural facilities nearby. Assistance available. Contact: Walter Curry, 200 Lambert Drive, Mt. Carmel, 62863, 618-262-4534. (4)

OLNEY: Weber Medical Clinic, 23 man multispecialty group. Population 100,000+, new building, patient load increased 20%. OB-GYN, Orth., Int., Ophth., Oto., Derm., Urol.; 5 weeks vacation, 1 week educational leave per year, pension plan, life insurance, disability. Lovely community, no ecology problems. Contact: David L. Potter, Adm., 1200 N. E. St., Olney, 62450, 618-395-2223. (4)

OTTAWA: Population 20,000. Opening in Internal Medicine at the Ottawa Medical Center, S.C. Eight-man specialty group. Seventy-five minutes from Chicago Loop. New hospital opening date in October, 1973. Contact: D. E. Morehead, M.D., 313 W. Madison St., Ottawa, 61350, 815-433-1010. (5)

PAW PAW "Rent Free" modern clinic available: Progressive, growing community, wishes to locate services of general practitioner. Modern medical, dental clinic provided. Maintenance of brick building by occupants only requirement. Excellent opportunity for profitable practice, plus ideal family living in friendly small town atmosphere. Contact: Mrs. Darlene McLaughlin, Paw Paw, 815-627-8441. (5)

PEORIA: Population 325,000. Emergency Room position for fulltime physician. Located midway between Chicago, St. Louis, and Iowa City. Excellent minimum salary and benefits. 824 bed community general teaching hospital, affiliated with University of Illinois Medical School. Illinois State Regional Trauma Center. Contact: Personnel Director, St. Francis Hospital, Peoria, 61603, 309-672-2304 (4)

PINCKNEYVILLE: Population 3,500. Opening in small Group-Partnership for Family Physician. Fully accredited hospital. Complete office facilities. No financial investment. Excellent compensation and working conditions. Sixty miles from St. Louis. Good recreational facilities. Contact: Clarence E. Cawvey, M.D., 206 No. Main St., Pickneyville, 62274, 618-357-2131. (4)

PONTIAC: Population 11,000. 100 miles south of Chicago on Route 66. 10 physicians. Several retiring. Wanted: Family Practitioners, General Surgeon (one on staff), Internal Medicine (none on staff). Paid Emergency Room coverage available. Financial and office space available. Contact: Dale Buddle, 610 East Walter St., Pontiac, 61764. Call collect: 815-844-5134. (4)

PRINCETON: Population 7,800; county population 38,000. Excellent living conditions; good family community—no problems. Modern 180-bed hospital. Unlimited income for Family Physiicans and Pediatricians. 2 hours—Chicago; 1 hour—Peoria & Quad Cities on I-80. Call collect: John Revell, 606 South Main St., Princeton, 61356, 815-872-1255 or 815-875-3292. (4)

PROPHETSTOWN: Small town boy?? If you are a physician interested in General Practice, and want a small town life for your family, then Prophetstown may be the place for you. We invite your inquiries. Contact: Calvin W. Schuneman, 343 Washington Street, Prophetstown, 61277, 815-537-2301. (4)

QUINCY: OB-GYN, Ped., Ortho., Fam. Prac., Derm., Ind. Med. to join 17-man established clinic. Large modern clinic, many benefits, two well-equipped hospitals. Excellent schools, cultural, recreational advantages. Good family city. Above average earnings. Write or call collect: Mr. Judson C. Green, Quincy Clinic, 1400 Main St., Quincy, 217-222-6550. (4)

RANSOM: General Practice Opening. Death compels sale of practice. Modern equipment and brick building—consists of doctor's, nurses and receptionist's offices, large reception room, laboratory and office-treatment rooms. 80 miles southwest of Chicago. St. Mary's Hospital staff in Streator, practice reaches a 50 mile radius. Contact: Mrs. D. Jones, Ransom, 60470, 815-586-4229. (4)

ROANOKE: General Practitioner. Population 2,050. Opening for one or two physicians. Excellent location for clinic-type facility. Financial assistance available. Space available, or will build to suit. Twenty-five miles from Peoria and Bloomington. All recreational facilities nearby. Contact: Elton Ulrich, Savings Building, Roanoke, 61561, 309-923-2831. (4)

ROSICLARE: G.P., Ped. Hospital serves 2 counties-approximately 10,000 people. Three Physicians at present. Office facilities, financial assistance & housing available. Modern, well equipped hospital. Located on Ohio River and in recreational area. Contact: Loeta Allen, Hardin Co. General Hospital, Rosiclare, 62982. Call collect: 618-285-6634. (4)

SALEM: G.P., Ped. Growing community with large rural area to serve. Financial assistance available. Fine schools and other municipal services. New 60-bed hospital addition under construction. Eighty miles from St. Louis. Contact: Edris Bachman, 520 Markland, Salem, 62881, 618-548-1944. (4)

SANDWICH: Population 5,500. 92-bed hospital serving 30,000. Need for two or three General Practice Physicians plus Internist plus Obstetrician plus Pediatrician. Single or group practice opportunities. The good life is here including economics, and also an hour from the Loop, etc. Contact: Marvin Tice, 11 East Pleasant Avenue, Sandwich, 60548, 815-786-8484. (4)

SAVANNA: G.P., Int. 5,000 population on Mississippi River. 40 bed open staff hospital. Excellent recreational facilities, excellent schools, churches of all denominations. Option to practice alone or in partnership. Financial assistance available. Contact: Wm. Dayton, 202 Meadow View Knoll, Savanna, 61074, 815-273-2221. (4)

SENECA: Wanted Family Physician—population 2,500, 70 miles southwest of Chicago. No doctor in town. Beautiful office building and equipment. Offer free rent with option to buy. Guarantee monthly gross. General Surgery knowledge helpful but not necessary. Two new hospitals—12 miles away with country driving. Contact: Marion L. Osborne, 135 E. Lincoln

St., Seneca, 61360, 815-357-6172. (4)

SHERIDAN: General Practitioner. One or two doctors for modern medical center. Financial assistance available including part-time staff physician for state institution. Excellent hospital facilities. Good opportunity for doctor who enjoys his family. Contact: John Yuhas, Sheridan, 815-496-2272 days or Alvin Sebby, Sheridan, 815-496-2620 evenings or weekends. (4)

SOUTHWESTERN TERRITORY: General Practitioner, towns of Brighton, Medora, Piasa, Shipman, combined area population 7,500. Office and facilities available; partnership and or financial assistance available. Five general hospitals in surrounding area, country living, excellent churches, schools, shopping areas. St. Louis and Springfield one hour away. Contact: Kenny Lahr, Piasa, 62079, 618-729-4142. (4)

STREATOR: Population 18,000. Multispecialty group, 7 physicians at present. New air-conditioned facility across from St. Mary's Hospital. Guaranteed minimum salary. Incorporated. Paid vacation and post-graduate study. Excellent insurance benefits. All specialties needed urgently. Contact: Dr. C. T. Hawkins, Streator Medical Clinic, S. C., 104 Sixth Street, Streator, 60364, 815-672-0511. (4)

STRONGHURST: Progressive small town serving large rural area. Close to large advanced medical facilities, recreational facilities nearby. No racial or environmental problems. Contact: Robert Dillon, Stronghurst, 61480, 309-924-6411. (4)

TAYLORVILLE: Population 12,000. Two-year old, seven physician multispecialty clinic seeking General Practitioners, Internists and OB-GYN. Salary first year. Full partnership thereafter. 25 miles to Springfield and SIU Medical School. 90 miles to St. Louis. Many recreational facilities nearby. Contact: Tom Brewer, 600 N. Main Street, Taylorville, 62568, 217-824-8191. (4)

WASHINGTON: Population 10,000 plus, need family physician; financial assistance available, office of doctor, recently retiring, with some equipment available. Ten minutes from Peoria. All recreational facilities available in or near Washington. 1 year free use of car provided, 6 mo. rent free residence available. Contact: Dean R. Essig, 139 Washington Square, Washington, 61571. (7)

WATSEKA: Population 5,800. Opening in established medical clinic, 4 Physicians at present. Complete office faciilties. Lab & X-Ray. Need GP and Internal Medicine. Contact: Francis Carter, 845 S. 4th Street, Watseka, 60970, 815-432-2461. (4)

WATSEKA: Population 5,800. General Practitioners needed. Clinic or single opportunity available. 16 physicians at present. Eighty-five miles from Chicago. New facilities, 114-bed hospital. Specialist available. Contact: Administrator or Chief of Staff, Iroquois Memorial Hospital, 200 Fairman Street, Watseka, 60970, 815-432-5201. (7)

WITT: Physicians needed in section of county to serve over 20,000 people. A modern building complete and ready for two doctors. Financial assistance available. Country living with access to big city attractions, St. Louis, Mo. Contact: Louis Schwartz, Witt, 62094, 217-594-2431. (9)

WOODSTOCK: Int., Ped. to join young 9-man multispecialty group in rapidly expanding area 60 miles NW of Chicago—Excellent Hospital—1st year minimum ($30,000)—Full member after one year—No buy-in's. Contact: Dr. Pensinger, Kishwaukee Valley Medical Group, S.C., 13707 W. Jackson St., Woodstock, 60098, 815-338-6600. (4)

Consumer, Payor, and Physician

Three differently motivated groups of human beings are involved in health care. The *first* of these is the consumer. He should have the highest priority but actually has a lowly position. He has limited health knowledge and *no organization.* The outstanding characteristics of this group, however, is that it has great and unsatisfied health needs. These needs could form the basis of an organized system for providing services. These needs can, and are, turning into wants and demands—especially if medical services are free or are believed to be free. This group of consumers has an enormous power potential—as yet unexercised.

The *second* of the three groups involved in health care is the payor. Increasingly the group that pays for health care is divorced from the consumer. The group that pays the bill has the right and obligation to be certain that the funds will be used effectively and efficiently. Sometimes the official representatives of this group are concerned with retaining the privilege of being representatives and have been known to engage in political expediency.

The *third* group involved in health care is our group—the people that provide the health care services. We have rights, privileges and obligations. We are well organized as professions and hopefully are most knowledgeable about health care. Admittedly without the consumer group we would not exist, and without the payor group we could not exist. We have the responsibility of producing a health system that will be comprehensive, effective, efficient, and of acceptable quality. This must be accomplished within the limitations of technical feasibility and financial capacity. (Thomas R. Wilson, M.D., "Quality Medical Care," *Selected Papers of the Carle Clinic and Carle Foundation,* Vol. 25, No. 2, (July) 1972, pp. 49-55).

BLUE SHIELD REPORT FOR Illinois Physicians

Public Information Messages Stress New Programs

A series of public information messages on Blue Cross-Blue Shield programs with emphasis on reducing the cost of health care services has been undertaken by our Public Affairs Department as a major consumer communication project for 1973.

Advertisements have begun to appear in major metropolitan dailies, 26 state area newspapers and other news media. Each message is keyed to health care costs. The copy refers to benefits available in Blue Cross-Blue Shield certificates. Booklets are also offered explaining benefits of the certificates in further detail. Copies may be obtained from the Public Affairs Department, Blue Cross-Blue Shield, 233 North Michigan Avenue, Chicago, Illinois 60601.

Coordinated Home Care Program

The first message featured Coordinated Home Care. The booklet uses the theme, "The Happiest Place to Get Well," and the ad with photo and caption "We need more hospitals like this one" illustrates the home as the place to recuperate after hospital confinement. The message intends to stress that when a patient is discharged from the hospital by his physician, his home environment very likely helps him return more readily to normal living and functional activity.



"Happiest Place to Get Well"—is the theme of booklet on Coordinated Home Care. The home pictured on booklet was also used on the ad with the caption "We need more hospitals like this."

The message pointed out further, that under the Coordinated Home Care Program, the continuity of treatment is established at the time of referral of a Blue Cross-Blue Shield member to the Coordinated Home Care Program. A planned program is developed by the patient's physician, the hospital nurse-coordinator and the participating home nursing agency. Benefits include necessary visits by the attending physician, home nursing service, medication, medical supplies, lab tests, X-rays, inhalation and physical therapy, and when the patient is able, a visit to the physician's office.

Figures are given that the average cost per day for Coordinated Home Care is significantly less than the average cost per day for in-patient care.

At present, 44 hospitals in Illinois are participating in this new program.

Pre-Admission Testing Program

The next message scheduled for mid-April and early May will be on the Blue Cross-Blue Shield Pre-Admission Testing Program. Its theme will be "How to save $8,000,000 by staying at home." The copy states that: "If everyone in Illinois who needed elective surgery could stay at home or on the job while the hospital conducted its pre-operative tests, all of us could save a lot of money."

The program is described briefly in the message; how it enables members to get their pre-surgical testing completed on an outpatient basis when approved by the physician and provides the physician with the opportunity to gather necessary data on the patient without hospitalization prior to elective surgery, thus reducing total expenditures.

The booklet on this program is entitled, "In 24 Hours This Man is Going to Have an Operation."

Other messages on the subject of health care costs are being planned and will appear during the year.

(This report is a service to the physicians of Illinois)

ASK BLUE SHIELD
. . . ABOUT MEDICARE

Revisions to Medicare Apply to New Premium Rate and Services in 1973

Changes in Medicare regulations that will affect Part B premium rates and a number of services January 1 and July 1, 1973 have been made in amendments by Congress.

The Social Security Administration announced that effective July 1, 1973 premiums for Part B Medicare insurance will be $6.30 a month, up 50 cents per month over the present rate. The higher rate is based on anticipated increases in the cost of the Medicare program for the period July, 1973 through July, 1974.

Under a new provision of the law there will be no further increases in the supplementary medical insurance premium until July 1, 1975, at the earliest, unless Congress enacts another general Social Security benefit increase during 1973.

The Department of Health, Education and Welfare estimates that about 22.5 million persons will be enrolled in Medicare in the coming fiscal year, including 1.7 million disabled persons under age 65 who are now covered by recent legislation. Medicare also covers those needing treatment for a chronic kidney disease that requires kidney transplantation or dialysis. This new protection is for workers insured under Social Security—wives, husbands and children—in fact all persons with this disability eligible for Social Security benefits.

In addition to actuarial determinations made from cost studies in the last premium period, the Social Security Administration said the new rate takes into account legislative changes in the Medicare program enacted in 1972, changes in the annual Part A and Part B deductibles, and eliminates the 20% home health services' Part B coinsurance effective January 1, 1973.

An amendment covering chiropractic services, effective July 1, 1973 limits coverage to "treatment by manual manipulation of the spine to correct a subluxation demonstrated by X-ray." The amendment provides coverage for a specified service and broadens the term, physician, to include chiropractors who meet specific qualifying requirements.

Coverage of speech pathology services furnished by approved providers under outpatient physical therapy benefits has been effective since December 31, 1972. Prior to the new amendment, those who were not eligible for home health benefits could receive these outpatient services only as incident to a physician's service or as a hospital outpatient service. Now services may be furnished by a physician, or in a clinic, rehabilitation facility or by a public health agency.

Completion of Part II, SSA 1490 Request for Medicare Payment

A commitment to publish the article in the March issue of the *Blue Shield Report* on the Precautionary Notice Legend on payments to Illinois physicians accepting assignment on Part B Medicare claims made it necessary to continue the article entitled "Complete Information Necessary on Medicare Claims" in this issue.

The concluding portion of the article follows:

Beginning with Part II of the form or attached itemized statements:

(7) Date of each service, place of service, full description of medical or surgical service, nature of illness or injury if not indicated in Part I, charge for each service.

(8) Name, address and telephone number of physician who provided the service. Please use the imprinted labels we furnish as these are specially coded to facilitate claim processing.

(9) Total charges.

(10) Amount paid.

(11) Any unpaid balance due.

(12) **Please complete this item. If the box "I accept assignment" is not checked, payment will be made to the patient.**

(13) Name and address of the facility where services were performed if other than home or office visits.

(14) Signature of physician. The signature certifies that the physician's services were personally rendered by him or under his personal direction; his professional degree and date of signature.

Please review all claims for completeness before you submit them. Claims completed correctly help us speed payments to you and your patients.

SSA Changes in Lab Certification

The Social Security Administration has made the following changes in the participation of laboratories under the Medicare program:

Approved for Medicare participation:
February 21, 1973
General Medical Laboratory, Ltd.
914 West Diversey Parkway
Chicago, Illinois 60657
Provider Number 14-8243

January 2, 1973
Immunologic Diagnostic Service
2501 West Devon Avenue, Room 207
Chicago, Illinois 60659
Provider Number 14-8241

Approved the withdrawal from Medicare participation:

April 1, 1973
Haven Clinical Laboratory
103 Haven Road
Elmhurst, Illinois 60126
Provider Number 14-8230

IMJ

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On the Cover

Newly elected 1973-74 ISMS officers are: (clockwise from the top) Willard C. Scrivner, M.D., *President;* Paul W. Sunderland, M.D., *First Vice-President;* James A. McDonald, M.D., *Vice Speaker of the House;* Jacob E. Reisch, M.D., *Secretary-Treasurer;* Andrew J. Brislen, M.D., *Speaker of the House;* Charles J. Weigel, M.D., *2nd Vice-President* and Fredric D. Lake, M.D., *President-Elect.* Pictured in the center is William M. Lees, M.D., *Chairman of the Board.*

ILLINOIS STATE MEDICAL SOCIETY

360 N. Michigan Ave., Chicago, 60601

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Professional Employers Covered By Occupational Health And Safety Act*

The U.S. Department of Labor has issued a ruling that any "member of a profession, such as an attorney or physician" who employs one or more employees is subject to Williams-Steiger Occupational Safety and Health Act of 1970. This would appear to apply equally to dentists, podiatrists, optometrists, accountants, and members of other professions. This interpretation of the Act appears in Title 29, Chapter XVII, Part 1975 of the Code of Federal Regulations.

Apart from limited classes of employers subject to other similar laws, it appears from these rulings that virtually every private employer is subject to the Act. Indeed, the only other private employers held by these rulings not to be covered are "individuals who, in their own residences, privately employ persons for the purpose of performing for the benefit of such individuals what are commonly regarded as ordinary domestic household tasks, such as house cleaning, cooking, and caring for children."

Every covered employer has an obligation to provide employees with a place of employment free from recognized hazards that are causing or are likely to cause death or serious physical harm and to comply with occupational safety and health standards promulgated by the Secretary of Labor. Many standards already have been promulgated by publication in the Federal Register. These include consensus standards adopted by standards-producing organizations, established federal standards, and other interim standards. With the assistance of the U.S. Department of Health, Education and Welfare other applicable new standards may be promulgated after a hearing.

Some standards, such as those relating to fire safety, structural safety, electrical safety, sanitation and the like, apply more generally to places of employment. Other standards apply more specifically to particular kinds of business enterprises. Employees are also required to comply with the standards. No specific standards for medical offices or clinics have yet been promulgated.

Each covered employer is required to display in a prominent place in the establishment to which employees normally report to work a poster supplied by the Occupational Safety and Health Administration of the U.S. Department of Labor. This poster gives information about the rights, obligations, compliance provisions and penalties under the Act. Beginning July 1, 1971, each covered employer is required to keep three records: (1) Log of Occupational Injuries and Illnesses (OSHA Form No. 100); (2) Supplementary Record of Occupational Injuries and Illnesses (OSHA Form No. 101); and (3) Summary Occupational Injuries and Illnesses (OSHA Form No. 102).

On Form No. 100 a current record must be kept for five years of all serious occupational injuries or illnesses. Serious injuries or illnesses are those which cause death, cause loss of workdays, result in transfer to another job or termination of employment, require medical treatment beyond first aid, involve loss of consciousness, or require restriction of work or motion. Reportable occupational illnesses are classified in the following categories: (a) occupational skin diseases or disorders; (b) dust diseases of the lung (Pneumoconiosis); (c) respiratory conditions due to toxic agents; (d) poisonings (systemic effects of toxic materials); (e) disorders due to physical agents (other than toxic materials); (f) disorders due to repeated trauma; and (g) all other occupational illnesses.

For each instance of occupational injury or illness reported on the log, more detailed information must also be recorded on OSHA Form No. 101. This requires substantial information on the cause of the injury or illness, the time and place where it occurred, and treatment given. At the end of each year, each covered employer is required to prepare, from information in the log, a summary of the instances of occupational injury or illness that occurred during the year on OSHA Form No. 102. This form must be posted in a place accessible to employees.

A covered employer is not generally required to submit these records to any government agency, but they must be available for inspection by

(Continued on page 382)

(*"*The Citation,*" Vol. 26, No. 5, published by the American Medical Association.)

Children Clinics Listed for May

Thirty-one clinics for Illinois' physically handicapped children have been scheduled for May by the University of Illinois, Division of Services for Crippled Children. The Division will conduct 23 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social, and nursing services. There will be six special clinics for children with cardiac conditions, and two for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children from whom he may want examination or consultative services.

May 1 Belleville—St. Elizabeth's Hospital
May 1 Fairfield—Fairfield Memorial Hospital
May 2 Hinsdale—Hinsdale Sanitarium
May 3 Sterling—Sterling Community Hospital
May 3 Lake County Cardiac—Victory Memorial Hospital
May 3 Litchfield—St. Francis Hospital
May 3 Effingham—St. Anthony Memorial Hospital
May 8 Peoria—St. Francis Children's Hospital
May 8 East St. Louis—Christian Welfare Hospital
May 9 Joliet—St. Joseph Hospital
May 9 Champaign-Urbana—McKinley Hospital
May 10 Macomb—McDonough District Hospital
May 10 Springfield—St. John's Hospital
May 10 West Frankfort—Union Mospital
May 11 Chicago Heights Cardiac—St. James Hospital
May 14 Peoria Cardiac—St. Francis Children's Hospital
May 15 Rock Island—Moline Public Hospital
May 15 E. St. Louis—Christian Welfare Hospital
May 16 Evergreen Park—Little Company of Mary Hospital
May 17 Anna—Union County Hospital
May 17 Elmhurst Cardiac—Memorial Hospital of DuPage County
May 17 Decatur—Decatur Memorial Hospital
May 17—Rockford—Rockford Memorial Hospital
May 17 Pittsfield—Illini Hospital
May 21 Peoria Cardiac—St. Francis Hospital
May 22 Peoria—St. Francis Hospital

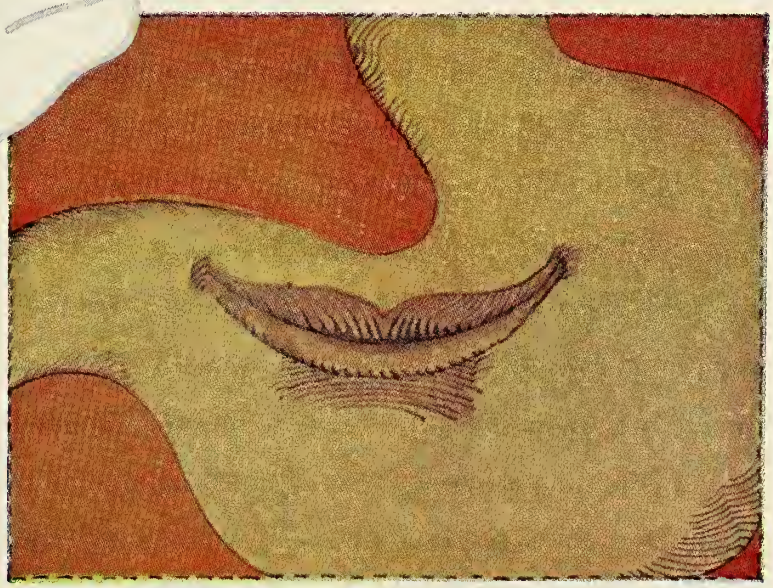
(Continued on page 336)

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Warnings. Thyroglobulin should not be used in the presence of cardiovascular disease unless thyroid-replacement therapy is clearly indicated. If the latter exists, low doses should be instituted beginning at 0.5 to 1.0 grain (32 to 64 mg) and increased by the same amount in increments at two-week intervals. This demands careful clinical judgment.
Morphologic hypogonadism and nephroses should be ruled out before the drug is administered. If hypopituitarism is present, the adrenal deficiency must be corrected prior to starting the drug.
Myxedematous patients are very sensitive to thyroid and dosage should be started at a very low level and increased gradually.
Precaution. As with all thyroid preparations this drug will alter results of thyroid function tests.
Adverse Reactions. Overdosage or too rapid increase in dosage may result in signs and symptoms of hyperthyroidism, such as menstrual irregularities, nervousness, cardiac arrhythmias, and angina pectoris.
Dosage and Administration. Optimal dosage is usually determined by the patient's clinical response. Confirmatory tests include BMR, T_3 ^{131}I resin sponge uptake, T_3 ^{131}I red cell uptake, Thyro Binding Index (TBI), and Achilles Tendon Reflex Test. Clinical experience has shown that a normal PBI (3.5-8 mcg/100 ml) will be obtained in patients made clinically euthyroid when the content of T_4 and T_3 is adequate. Dosage should be started in small amounts and increased gradually with increments at intervals of one to two weeks. Usual maintenance dose is 0.5 to 3.0 grains (32 to 190 mg) daily.
Overdosage Symptoms. Headache, instability, nervousness, sweating, tachycardia, with unusual bowel motility. Angina pectoris or congestive heart failure may be induced or aggravated. Shock may develop. Massive overdosage may result in symptoms resembling thyroid storm. Chronic excessive dosage will produce the signs and symptoms of hyperthyroidism.
(Treatment: In shock, supportive measures should be utilized. Treatment of unrecognized adrenal insufficiency should be considered.)
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The President's Page

The Need for a Large Membership

In my inaugural address at our annual meeting last month, I outlined a Program of Progress for the coming year . . . a program designed to re-affirm the role of physicians as leaders in the health care system.
Here is my formula for its success: UNITY + STRENGTH = EFFECTIVENESS.

The foundation of this program, and of our medical society, is the UNITY of Illinois physicians. To assert our position as leaders at a time when the specter of government intervention into health care threatens our profession, we must speak with a unified voice.

To forge a more unified state society, we must above all increase our membership. Because the STRENGTH of any association is directly proportional to the size of its membership.

While no association can represent the views of each of its members on all issues, nor should it be expected to, ISMS does serve and represent the general interest of the overwhelming majority of Illinois physicians.

Our most valuable asset is the knowledge and expertise of our members. I emphasized in my inaugural address that each member is a vital link in our organizational chain . . . a chain no stronger than its weakest link. For through UNITY comes STRENGTH and they equal EFFECTIVENESS.

Our futures depend on our effectiveness in dealing with the problems facing the health care system and our profession . . . and this effectiveness in turn depends on our membership.

The ISMS membership picture, on the whole, is a reasonably bright one. For the first time in our history we have broken the 11,000-member barrier. In the 1960's we leveled off at slightly above 10,500 members. By 1970 we had begun to climb a little and at the end of 1972 the membership stood at 10,914. Today it is more than 11,000.

That's not too bad. But it is still far short of the potential of almost 15,700 M.D.'s (including over 2,000 Residents) registered in Illinois today.

What, then, should we do to increase our membership during the coming year?

I have been using the word "our" in reference to ISMS. But since we have a unified membership system in Illinois—and I am all for that—then in a broader sense I also mean the county societies and AMA when I say "our."

In any case, I don't think the unified membership system needs to be defended. There are certain things that can best be done at the county level, other things at the state level and still other things at the AMA level. What these things are has been spelled out elsewhere and needs no repetition here.

Currently, ISMS and the Chicago Medical Society are working to establish a joint membership committee that will formulate an intensive recruitment campaign in Cook County. This has particular urgency because by far the greatest number of non-members are in Cook County.

But there are hundreds of non-member physicians downstate as well. And so these guidelines apply to most county medical societies.

First of all, **form a membership committee:** This is essential if you hope to have a successful program. One group of three to five physicians should be assigned the responsibility for building membership. They should be individuals who have dedication, desire and drive to plan and implement the program.

Review your constitution and bylaws: Many societies have requirements that place severe limitations on who is eligible for membership. By modifying or changing some of the requirements, you may open the door to a substantial number of new members.

Identify your membership potential: Within your society's geographical area there undoubtedly are many physicians who are eligible for membership that you are simply not aware of. Upon request, ISMS will provide you with a listing of non-member physicians in your county.

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Perforated Jejunum Due to Primary Hodgkin's Disease

By Takashi Okuno, M.D. and H. Paul Carstens, M.D./Park Ridge

A report of "Hodgkin's disease exclusively with bone marrow involvement" (JAMA 214:2197, 1970) prompted us to report a patient who had showed unusual manifestations and involvement of the jejunum by Hodgkin's disease, complicated by multiple perforations as the primary symptomatic presentation. Although non-Hodgkin's malignant lymphoma of the small intestine often have been reported, the primary involvement of the jejunum by Hodgkin's disease is rare[4]. Further, Hodgkin's disease of the small intestine as a cause of perforation is extremely rare[1]. In the present case, both at exploratory laparotomy and at autopsy, it was confirmed that no other organs were involved except for mesenteric lymph nodes.

Case Report

A 50-year-old woman was admitted to the hospital with chief complaints of fever and abdominal cramps for four weeks duration. The abdominal cramps had been relieved by liquid mucoid bowel movements occurring four to five times a day. The symptoms persisted with fever to 104°F until admission. She had lost 10 pounds during the past several months. On physical examination no lymph nodes were palpated. The abdomen was flat. Bowel sounds at admission were very hypoactive. Marked rebound tenderness was greatest in the left lower quadrant.



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H. PAUL CARSTENS, M.D., is on stoff at Lutheran Generol Hospital, Cook County Haspital and Northwest Community Haspital. Dr. Carstens, an internist, is on Assistant Professor of Medicine, Northwestern University School af Medicine.

The laboratory results showed Hgb. 12.6 g/100 ml, Hct. 37.9% and WBC 4,000/cumm, with metamyelocytes 2, bands 10, polys 81, and lymphocytes 7%. Coombs, fluorescent antinuclear antibodies, Lupus Erythematosis cell test and Latex fixation test for rheumatoid arthritis were all negative. X-ray films of gall bladder, upper G.I. series, and chest on admission were normal.

On the 12th hospital day, an exploratory laparotomy was done. Considerable contamination of the peritoneal cavity with perforations of jejunum was found. Seven perforated areas were inverted and closed with silk and chromic sutures. Several loops of the jejunum were resected.



Figure 1. Ulcerated jejunum showing dense anaplastic cellular infiltration at the ulcer crater. The section is taken at exploratory laparotomy.

The surgical specimen revealed two perforating ulcers of the jejunum. The largest one measured 3 cm in its largest diameter. The margin of the ulcer was rather sharp with deep crater, which was covered with yellowish fibrinous exudate (Figure 1). The ulcers were located in circular fashion. One enlarged lymph node was found in the mesentery which measured 2 cm in diameter. Microscopically, the ulcerated area was diffusely infiltrated by anaplastic reticulum cells with many Reed-Sternberg cells (Figure 2). The lesion was diagnosed as Hodgkin's disease, reticular type, according to Luke's classification.[3]

Postoperatively the patient was treated with prednisone, 100 mg daily, and 2500 R. cobalt therapy. The cobalt therapy soon was discontinued because of spiking temperature and shortness of breath with holosystolic murmer, suggestive of bacterial endocarditis. Electrocardiogram showed left bundle branch block. Subsequently, blood culture grew gram negative bacteria, Mima-Herellea species. Keflin 12 gm daily intravenously was started. She died on the 21st post-operative day.

At autopsy, small vegetative bacterial endocarditis was present on the mitral valve of the heart. The jejunum showed several rather shallow ulcerations measuring up to 2 cm in diameter. All of the ulcers were distributed circular in fashion. Several mesenteric lymph nodes were enlarged, the largest of which measured 3 cm in diameter. No other organs including the spleen, liver, and bone were involved. Histologic sections of the autopsy confirmed the diagnosis previously made at the exploratory laparotomy.

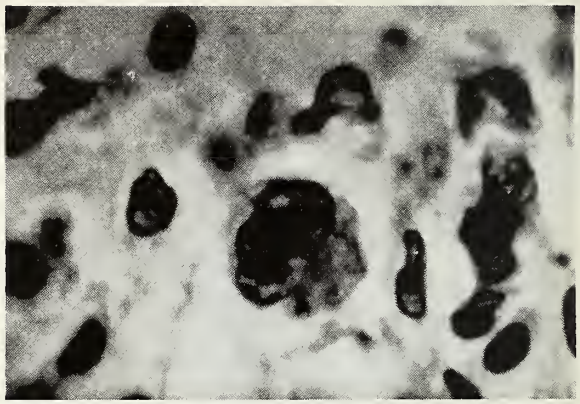


Figure 2. Higher magnification of the section showing Reed-Sternberg cell and reticular cells.

Comment

Several hundred cases of primary lymphosarcoma of the small intestine have been reported, but primary involvement of Hodgkin's disease is considered to be extremely rare.[5] Most of the cases of small intestine Hodgkin's disease are located in the jejunum. The lesions are usually small and tend to show longitudinal extension along the submucous layer[4] although this case presents an encircling lesion. About one-third of the cases are ulcerative in nature, and the rest are either polynoid or aneurysmal type.[1] Almost all cases present symptoms referable to the abdomen such as abdominal pain, nausea, or constipation.

Free perforation of primary Hodgkin's disease of the small intestine is extremely rare. Thus, Faulkner and Dockerty can find only one such case in the literature in which Hodgkin's disease continued to the point that perforation had occurred.[1] Thirteen cases of perforating lymphosarcoma of the small bowel are reported among 37 cases of primary sarcoma of the small intestine, but none of the 13 cases are Hodgkin's disease; ten are reticulum cell sarcoma and three are lymphosarcoma.[2] ◄

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Viral Labyrinthitis and Transient Phrenic Nerve Paralysis

By J. V. Forrest, M.D., Felipe S. Chua, M.D., and Peter A. Brusca, M.D./Hines

Transient phrenic nerve paralysis associated with viral labyrinthitis is obviously very rare. The absence of documented cases in the literature attests to this fact. This article presents what we believe to be the **first reported case** of transient phrenic nerve paralysis associated with viral labyrinthitis.

Case Report

A 33-year-old Caucasian male was supine, watching television, when he suddenly experienced an episode of whirling vertigo when he attempted to rise. The vertigo continued until he became nauseated and vomited. He had difficulty sleeping that evening because turning or sitting made him very vertiginous. This attack was not accompanied by tinnitus, hearing loss, nor was there any history of trauma. He denied having any upper respiratory tract infection within the last week prior to admission. Nothing else in the history was significant.

Physical examination was within normal limits except for spontaneous nystagmus with the fast component to the left when the patient sat up. Weber and Rinne tests were both normal. The laboratory studies, which included complete blood count, urinalysis, throat and nose culture, skull films and lumbar puncture, were reported normal.

The routine chest X-ray showed marked elevation of the right hemidiaphragm (Figure 1). Subsequent fluoroscopic examination revealed paradoxical movement of the right hemidiaphragm. A routine chest X-ray taken two months earlier was normal (Figure 2).

The patient was placed on Betahistine Hydrochloride and Dexbrompheniramine-Pseudoephedrine sulfate for his vertigo. During his hospitalization he had more abrupt paroxysms of vertigo.

By the sixth hospital day his vertigo subsided and he was able to sit up, turn his head, and walk with little or no difficulty. The nystagmus was no longer present.

The patient was discharged asymptomatic on the eighth hospital day with a normal chest X-ray (Figure 3) and normal fluoroscopic examination. His repeat chest X-ray and fluoroscopy two weeks after discharge were likewise normal.



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Discussion

This interesting case is an unusual presentation of viral labyrinthitis. Transient or otherwise, phrenic nerve paralysis is not known to accompany viral labyrinthitis.

The predominant symptom of this labyrinthine disease is vertigo, termed aural vertigo. It tends to occur in paroxysmal attacks with abrupt onset. The nausea, vomiting or pallor that may be present tend to be short-lived. The accompanying nystagmus is most pronounced when the eyes are turned away from the offending labyrinth.

Viral labyrinthitis fits perfectly the clinical picture presented by our patient, except for the

accompanying elevation of the right hemidiaphragm. All other conditions, such as vertebrobasilar insufficiency, cerebral embolism, diabetes mellitus and other disease of central nervous system origin, were ruled out. Other causes of labyrinthine disease had been excluded. The patient's immediate recovery following an apparently self-limited disease, is compatible with viral infection of the labyrinthine structures.

The markedly elevated right hemidiaphragm on the admission chest X-ray was not present two months prior to this hospitalization. The chest X-ray on the day of discharge and two weeks following this, together with fluoroscopic studies on both occasions, revealed normal findings. These indicate the transient nature of the phrenic nerve paralysis.

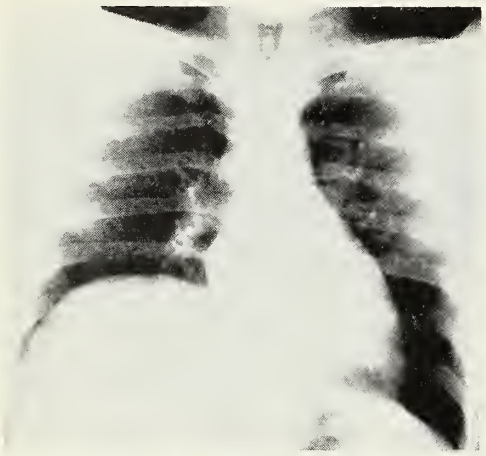


Figure 1. Admission chest film taken in April, 1969. There is marked elevation of the right hemidiaphragm.



Figure 2. Routine chest film taken in February, 1969. Normal.

The timing of the onset of the labyrinthitis and the elevation of the right hemidiaphragm, and their simultaneous subsidence, strongly suggest the possibility of a common viral etiology for both conditions.

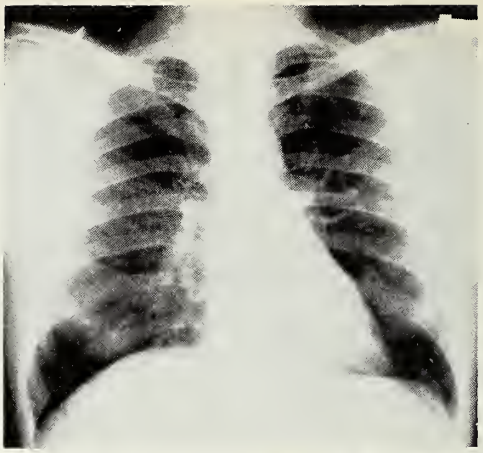


Figure 3. Chest film taken on April 23, 1969, prior to discharge from hospital. The film is again normal.

Spears in 1963 described the third case in the literature of transient phrenic nerve paralysis associated with herpes zoster. We found no report describing the association of phrenic nerve paralysis with viral labyrinthitis.

The other possible causes of phrenic nerve paralysis were excluded in this patient; among these conditions were: 1. Abnormalities or injuries of the cervical portion of the spine; 2. Compression of the nerve by tumor masses in the neck or mediastinum; 3. Pressure from aortic aneurysm; and 4. Neuropathy of lead poisoning.

Upward displacement of the diaphragm secondary to intraabdominal masses, ascites and marked obesity were obviously not present in this case.

The clinical and radiologic findings in this patient are compatible with a transient right phrenic nerve paralysis.

Summary

A case of a 33-year-old Caucasian male with viral labyrinthitis and associated transient phrenic nerve paralysis is presented. The timing and sequence of events in the course of this patient strongly suggest the possibility of a common viral etiologic denominator for both clinical conditions. ◄

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Pediatric Perplexities

Jaundice Due to Urinary Tract Infection

By Ruth Andrea Seeler, M.D.

Pediatric Hematologist, Cook County Hospital & Hektoen Institute/Chicago

"Pediatric Perplexities" is a series of encounterable, but slightly uncommon, pediatric disorders which require prompt diagnosis and specific management for a good outcome. Initially, the series will be based on patients seen by the author at the Cook County Hospital, Division of Pediatrics. The author welcomes suggestions for types of cases that the readers would like to have presented and discussed. This series will alternate with the maternal death studies.

A 26-day-old male infant was perfectly well until three days prior to admission, when his mother began to notice the onset of dark urine accompanied by lethargy and decreased appetite. Previous to the present illness, the child had been fed a commercial formula with iron and taken it well. On the day of admission, the mother noted that the child was jaundiced. The birth weight was 5 lbs. 8 ounces and the neonatal course was unremarkable.

Physical examination revealed a markedly dehydrated, jaundiced, irritable child who was very lethargic. The weight 4 lbs. 7 ounces, pulse 130 per minute, respirations 56 per minute. Positive physical findings included icterus and a liver which extended 4 cm below the costal margin and a palpable spleen. The child had a good cry, but was mildly hypotonic.

Laboratory data included a total bilirubin of 27.6 mgs% with 11.6 mg% direct reacting. The BUN was 42 mg%, the sodium 125 mg%, potassium 6.6, chloride 105, the CO_2 combining power 6.4 and the pH was 7.29. Urinalysis showed proteinuria and on microscopic it was loaded with WBC and bacteria. The infant was 0+, direct coombs negative and the mother was 0+ with no detectable irregular antibodies. Serological tests for syphilis on the mother and the infant were normal. G6PD screening on the infant was negative. The hemoglobin was 10.1 gms%, hematocrit 31% with a reticulocyte count of 2.6%. The WBC was 33,700 with 33 polys, 39 bands, 1 meta, 1 myelo, 1 blast, 19 lymphs, 6 monos and the platelets appeared decreased.

The diagnosis of gram negative urinary tract infection with secondary hemolysis was made. The urine culture grew greater than a 100,000 colonies of *E. coli,* which was subsequently typed by CDC as 04:H1. Treatment with ampicillin and kanamycin had a good response. The severe acidosis was initially treated with bicarbonate infusions. All parameters rapidly returned to normal and the child made an uneventful recovery. I.V.P. was subsequently normal.

Discussion

Urinary tract infection with or without septicemia continues to be a significant etiological factor in jaundice in young infants. The jaundice is the cumulative result of a toxic hepatitis and hemolysis. In our series of 22 infants with this condition the bilirubins have ranged as high as 48.2mg% with 24.6mg% direct reacting bilirubin. Except for very young infants (under 10 days of age) there has been both a direct and indirect hyperbilirubinemia.

Uniformly these infants have a hemolytic anemia with a more rapid fall in hemoglobin and hematocrit than can be accounted for by red cells aplasia. The initial absence of reticulocytosis is merely the result of the severity of the septicemia. With recovery there is a reticulocytosis in return of the hemoglobin to normal. The WBC in this condition is usually elevated with a marked predominance of granulocytes and early granulocytic forms including myelocytes and occasionally blasts. Döehle bodies have been regularly found in polymorphonuclear leukocytes. Thrombocytopenia is another common accompaniment of this syndrome and is another manifestation of the gram negative bacteremia.

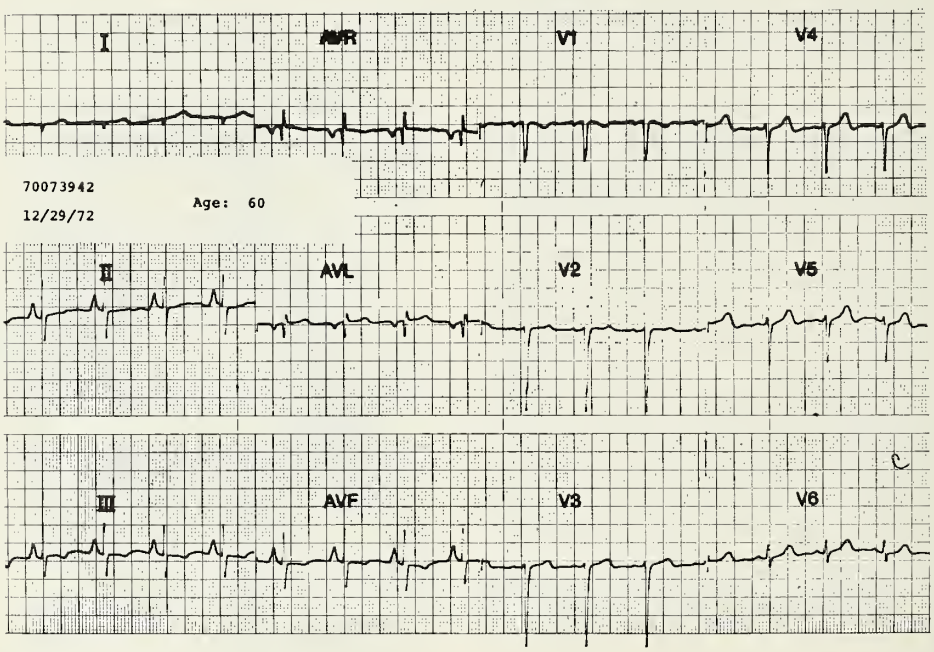
The BUNs have ranged from 18-153mg%. Most of the infants are moderately or severely acidotic as judged by the CO_2 combining power and actual pH determinations.

Most infants are below birth weight or not gaining as expected. These infants are very easily

(Continued on page 359)

ekg of the month

John R. Tobin, M.D., M.S., Rimgaudas, Nemickas, M.D., Patrick J. Scanlon, M.D., John F. Moran, M.S., M.D., James V. Talano, M.D., Sarah Johnson, M.D. and Rolf M. Gunnar, M.D., M.S./Section of Cardiology, Loyola University Stritch School of Medicine



This 60-year-old white male was admitted with a history of a nonproductive cough of two years duration, progressive dyspnea on exertion and ankle swelling of two weeks duration. On physical examination mild cyanosis of the lips and fingers, clubbing of the nails and increased AP diameter of the chest were noted. Cardiovascular examination revealed a loud pulmonic closure and an intermittent S_3 best on inspiration. There was moderate ascites and pretibial edema.

Questions:

1. **The P wave in this electrocardiogram:**
 (a) is characteristic of P-mitral
 (b) is characteristic of P-pulmonale
 (c) has a P wave axis in the frontal plane of greater than 60°
 (d) is characteristic of a coronary sinus rhythm

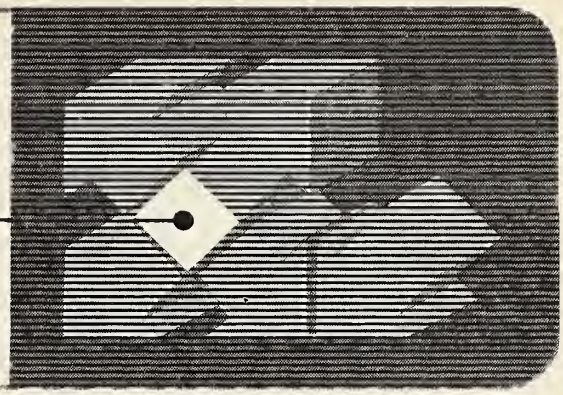
2. **This electrocardiogram could be compatible with:**
 (a) left anterior hemiblock
 (b) old extensive anterior myocardial infarction
 (c) left ventricular hypertrophy
 (d) cor pulmonale

3. **The history and physical findings and the electrocardiogram are most compatible with the diagnosis of:**
 (a) severe mitral stenosis
 (b) anterior myocardial infarction
 (c) ASD with pulmonary hypertension (Eisenmenger's physiology)
 (d) cor pulmonale secondary to chronic obstructive lung disease

(Answers on page 387)

Trauma Center

David R. Boyd, M.D.C.M., Editor



Immediate Transfusion Reaction: Fact and Fancy

By Robert J. Baker, M.D., Robert J. Lowe, M.D. and David R. Boyd, M.D.C.M.

TRANSFUSION of whole blood and blood components became an intrinsic part of medical practice 35 years ago. Important developments and newer techniques introduced in the past 15 years have rapidly increased the indications for such therapy. This has been coupled with an increased need due to the astronomical rise in the frequency of major high speed automotive trauma, necessitating more heroic resuscitative and operative maneuvers.

At this time, over 6,000,000 units of whole blood are drawn and used in the United States annually. These are administered in one or several forms (Table I). Approximately 2,500 deaths occur each year as a direct result of transfusion of the blood or one of its several components, a mortality which is calculated to include 0.1% of all recipients. Higher figures have been reported from Europe and Asia, but realistic prospective analyses are not available. The prime cause of death has been serum hepatitis, now significantly decreased by routine testing for hepatitis-associated antigen (HAA) and, most important, by recent legislation enacted by the Illinois Legislature eliminating the "commercial," or paid donor. Blood from these donors has been shown to cause a 20 times higher incidence of serum hepatitis following infusion than that obtained from "replacement" donors, those donating blood for family, friends, or as part of a blood assurance program.



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Immediate transfusion reaction is that reaction which occurs within 24-48 hours of transfusion, most frequently during or immediately following the administration period. Excluded from further consideration is serum hepatitis, despite its importance, but which occurs from 35-120 days after the infusion. Also excluded is the rare occurrence of transfusion-borne brucellosis or malaria. An omnipresent hazard is isosensitization, in which demonstrable antibodies to one or several red-cell borne antigens develop after 10 days to three weeks.

Table I

Blood Components Available

	Type	Indication for Use
CONTAIN RED CELLS	1. Whole blood, A.C.D. or C.P.D.	Acute massive bleeding
	2. Packed red cells	Correct anemia, blood replacement in elderly
	3. Ultrafresh whole blood (24 hrs. old)	Thrombocytopenia
	4. Frozen red cells	Acute bleeding, anemia
DO NOT CONTAIN RED CELLS	5. Platelet-rich plasma	Thrombocytopenia
	6. Fresh frozen plasma	Plasma prothrombin precursor deficit
	7. Cryoprecipitate (Pool factor)	Hemophilia with acute bleeding
	8. Serum Albumin	Increase blood volume
	9. Gamma globulin	Prevent hepatitis (?), hypogammaglobulinemia
	10. Lyophilized fibrinogen	Hypofibrinogenemia NOT due to disseminated intravascular coagulation (or after treatment)

Such isosensitization can cause erythroblastosis fetalis if the recipient of the red cells or whole blood is a female in the child-bearing age group, or may sensitize the recipient to future transfusions. If proper crossmatch techniques are not employed (as in "universal donor" transfusions), serious hemolytic reactions may result.

Description of Reactions

A realistic classification of immediate transfusion reaction must include all untoward happenings in the 48 hours during or following transfusion attributable to the whole blood or packed cells given. Other non-red cell containing components may cause some of these, but seldom do and are generally not of concern (Table II). These are also to be distinguished from several metabolic changes accompanying "massive" transfusion, defined as the administration of a volume of blood equal to or greater than the recipient's measurable circulating blood volume in 12 hours or less. A normal-sized adult is roughly 7% whole blood by weight; hence, a 70 kilogram man has a measurable volume of 4,900 ml, if he is neither very obese nor cachetic. Administration of volumes of blood in excess of 10 units to such a patient in a short period of time may result in any of the therapeutic side-effects listed in Table III, the so-called "storage lesion."

Allergic Reaction

The commonest of the immediate transfusion reactions, occurring in 4% of all recipients of red cell units, is the *allergic reaction.* It is characterized as follows:

A. Itching, almost invariable in the conscious patient
B. Urticaria, blotchy erythema, in ⅔ of patients with this reaction
C. Chills, 60% of reactors
D. Fever, 60% of reactors
E. Respiratory distress, rare (less than 1%)

Patients with a history of hay fever, asthma, or atopy as children have a 50% incidence of these reactions and should be warned about the possibility prior to transfusion. Also, patients with a history of previous allergic transfusion reaction have a very high incidence of repeat allergic pneumonia. *Recognition* of this reaction is of paramount importance, since it may simulate

Table II

Immediate Transfusion Reactions

Type of Reaction	Incidence	Red Cells Required
Allergic Reaction	45%	Usually
Febrile Reaction	43%	Usually
Hemolytic Reaction	10%	Always
Miscellaneous	2%	No
Pyrogen infusion, bacteremia, specticemia, circulatory overload		
	100%	

Table III

"Storage Lesion" of Banked Citrated Blood

Lesion	Comment
1. Acidosis	Followed in 12-36 hours by alkalosis
2. Hypothermia	In-line warming devices will prevent
3. Citrate overload	Prevent with 1 gram calcium salt per 2 units whole blood
4. Hyperkalemia	Use packed cells or frozen cells to decrease potassium input
5. Hyperammonemia	Of questionable importance
6. Coagulation defects	Deficits in platelets, Factors V, VII
7. Decreased resistance in infection	? Impeded bacterial phagocytosis

hemolytic transfusion reaction, with which it *must not* be confused. Characteristically, at least ½ unit of whole blood or packed cells is required to cause an allergic reaction. Therefore, the advent of symptoms *early* in the transfusion, when only chills and fever are present, is strong evidence against allergic basis. If, however, almost the entire unit has been infused, hemolytic reaction is most unlikely as a cause of chills and fever. Likewise, urticaria *only* occurs with allergic reactions, never with hemolytic ones. The temperature rarely exceeds 103° F.

TREATMENT of allergic transfusion reaction should be:

A. Do NOT stop the transfusion
B. Diphenhydramamine (Benadryl), 50 mgms IM
C. Salicylate, 600 mgms

If necessary:

D. Epinephrine, 0.3 mgm IM
E. Hydrocortisone, 100 mgm IV

The patient should be observed closely for 30-60 minutes; a favorable therapeutic response is expected in that time.

Febrile Reaction

This reaction is observed almost as frequently as allergic reaction, with identical sysmptoms except that urticaria and blotchy erythema are not observed. Originally thought to be a variant of allergic reaction, it now has become apparent that well over half of these reactions are caused by leukocyte antibodies in the recipient. Leukagglutinins can frequently be demonstrated following febrile transfusion reactions, unlike allergic ones. As in allergic reactions, 200 ml of whole blood, or more, is required to cause any reaction. These reactions are much more frequent in previously transfused recipients, and can be prevented by using packed, washed red cells, resuspended in saline, Ringer's lactate or serum albumin. An alternative is to infuse blood through a commercially-available nylon leukocyte filter which removes most of the infused white cells.

Treatment is identical to that of allergic reactions, and is basically symptomatic. It is important to recognize this reaction, so that subsequent infusion of white cells can be avoided.

Hemolytic Transfusion Reaction

This reaction is potentially the most dramatic, certainly is the the most hazardous, and is relatively rare, occurring in a severe, life-endangering form in one in 3,000 recipients.[1] The mortality rate in this fulminant form of the reaction varies from 15-25% in various reported series. However, two other forms of hemolytic reaction are also seen: (a) post-transfusion hemolytic jaundice, accompanied by minimal hemoglobinuria, and rapidly developing jaundice, from 24-96 hours after transfusion; few, if any, symptoms accompany these changes; (b) intraoperative or immediate postoperative diffuse bleeding, usually accompanied by hypotension and tachycardia.[2]

The fulminant type of hemolytic transfusion reaction can occur with as little as 10 ml blood infused, and rarely requires more than 75-100 ml for symptoms to present. In general, the severity of the reaction is inversely proportional to the volume of blood (or packed cells) required to cause the reaction. Hemolytic transfusion reaction *only* occurs when red cells are transfused in some form. Symptoms occur usually in the following order:

A. Chills
B. Fever
C. Tachycardia
D. Chest pain, "tightness"
E. Flank pain
F. Dyspnea
G. Nausea, vomiting
H. Hematuria, hemoglobinuria
I. Oliguria
J. Shock

Since chills and fever herald the onset, it is important that patients always be observed during the first 40-50 cc of blood infused, and any untoward symptoms be noted and appropriately dealt with. As a rule, the greater the volume of incompatible blood infused, the worse the prognosis. If patients experience the entire range of symptoms, progressing to shock, survival is most unlikely.

The concept of the pathophysiology of acute hemolytic transfusion reaction has changed considerably in the past five years. It is now recognized that the reaction triggers sudden systemic disseminated intravascular coagulation (DIC) and many of the symptoms are related to the microvascular clotting which occurs. The propensity of the kidney and myocardium to be affected is not unlike systemic DIC from other causes, and treatment should be directed to

arresting the process with large doses of intravenous heparin, and other agents.

Currently preferred treatment of the full-blown process consists of:

A. STOP TRANSFUSION
B. Send blood sample, urine to lab
C. Heparin, 500 mgms (50,000 International Units) IV
D. Mannitol, 20 gms IV
E. Furosemide (Lasix), 40 mgms IV
F. Na bicarbonate, 45 mEq (50 cc of 7.5% solution)
G. Water load 1,000 ml Ringer's lactate in 30 minutes
H. Prevent hypotension (isoproterenol, rarely metaraminol)
I. Continue to transfuse *after*, repeat after, crossmatch and identification of error

It is tragic that fulminant hemolytic transfusion reaction is uniformly preventable with appropriate typing and crossmatching procedures. When this reaction occurs, there has always been an error of the worst kind, usually in labelling blood in the laboratory or occasionally in failure of identification of appropriate recipient and matched blood donor. The latter is especially apt to occur in the operating room under crisis conditions, but the surgeon must be aware that he is responsible for hemolytic reactions whenever they occur. It is advisable, therefore, that procedures be established whereby the operating surgeon always checks the blood bag label prior to the starting of the blood infusion, no matter how engrossed he may be in the problem at hand.

The somewhat delayed hemolytic reaction is more common, and is manifest by the rapid appearance of jaundice in 24-72 hours, without specific accompanying symptoms.[3] Unfortunately, serologic identification of the specific nature of the major hemolysis is usually not possible, and may lie in the presence of a weak recipient antibody which is augmented when antigen-containing red cells are administered.[2] Massive sudden bleeding on the operating table is always suggestive of some form of consumption coagulopathy, in this case of systemic DIC. Immediate heparinization is mandatory, using 500-1,000 mgms (50,000-100,000 I.U.) intravenously. Bleeding is diffuse, from all possible sites, and will usually subside slowly, in from 30-90 minutes. It may be necessary to repeat the heparin dosage every 3-6 hours if bleeding recurs.

Miscellaneous Reactions

Pyrogenic reactions, with high fever, tachycardia and malaise occurs primarily when reusable equipment was employed. However, with the advent of the plastic closed-system apparatus, these have essentially disappeared, and pyrogenic reactions are no longer part of the differential diagnostic considerations when fever occurs during or after transfusion. Several instances of sudden unexplained fever have occurred following the addition of medications of various sorts to blood and blood by-products. It should always be a firm rule that nothing be added to these.

Bacteremia and septicemia following transfusional therapy is extremely rare, as most bacteria contaminating freshly drawn units are non-cold growing, and are effectively inhibited by the blood bank storage temperature of 4-8° C. Organisms which occasionally do grow in the cold and are capable of utilizing citrate as a carbon source are Pseudomonas paracolar oraginsms and *Escherichia coli.* Interestingly, gross contamination with the latter organisms can usually be recognized by inspection, as the supernatant plasma quickly becomes dark brown, or even black. If contaminated blood is administered, hyperpyrexia, toxemia, septic shock or a massive consumption coagulopathy may ensue within two to 24 hours. Prevention is far superior to treatment; any discolored or suspiciously dark unit of blood should be returned to the blood laboratory for culture, and other units obtained.

Circulatory overload is not, strictly speaking, a reaction so much as a therapeutic error. It can usually be prevented by careful monitoring of central venous pressure (CVP) when large volumes of blood or other colloid are infused. CVP should not be allowed to rise above 15 cms of water except under the most unusual circumstances. Digitalization, diuretics (furosemide) and careful crystalloid infusion should be employed when overload is suspected.

Low Titer Universal Donor Blod

Traditionally, blood banks have kept several units of type O, Rh negative blood on hand, usually containing low anti-A and anti-B titers. This blood has been used without crossmatch procedures when patients are brought to the hospital in extremis from severe acute hemorrhage. Ruptured extopic pregnancy, ruptured uterus, ruptured abdominal aortic aneurysm,

(Continued on page 363)

Psychiatric Emergencies of Childhood and Adolescence

By Domeena C. Renshaw, M.D., M.B., Ch.B./Maywood

It is well known that there is a severe shortage of child psychiatrists, while there are large numbers of children who have psychiatric problems requiring care. Attempts to meet these needs continue. Meanwhile, the family physician or pediatrician are still the front-line men for families when emergencies and crises arise. An outline is given of the more common crises that bring children and adolescents to the doctor's office. In the light of current knowledge, possible management is suggested to make optimum use of the valuable time of the professional, whether in a single encounter or in brief follow-up visits.

Outline of Emergencies

I. Danger to self or others
- suicide threat or attempt
- homicidal threat or attempt
- physical violence, by or to the child
- fire-setting

II. Sexual Emergencies—by, to, or around the child

III. Bizarre behavior of acute onset

IV. Crisis in key person-parent, teacher, social worker, police

V. School phobia

General Principles of Management

See and evaluate the child or adolescent *alone* first, to preclude observer bias by a catalog of complaints, where the atmosphere does not allow for comfortable expression on the part of the child. Such recognition of the dignity of the child, by giving privacy and total attention, is reassuring to the child and most rewarding to the examiner in the picture so obtained. The two-year old who comes in alone readily or the clinging eight year old who resists separation already reveal important data. Some children are difficult to interview (as are adults) when they are anxious, angry or poorly articulate. However, the understanding that he is angry or anxious and verbalization of same by doctor to child, goes a long way towards facilitating opening up by the child. The objective is to evaluate the status of the child, not to elicit precise legal information. Usually the parent or responsible adult will have plenty of information, which the doctor will have to place in perspective.



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Suicide Threat or Attempt

This frequently brings the surprisingly young child to emergency rooms or doctor's offices. Parents will at times tolerate attempts that do not cause marked damage and dismiss them as experimentations of the child (for example, attempted drownings in the tub by a six-year-old who came to treatment after the third somewhat serious attempt.) Physicians should not fall into the same trap of "he's only a child." As with suicide threat or attempt at any age, the professional responsibility is to get a good history, to evaluate, then to treat.

Since analysis of children with psychiatric emergencies in Emergency Rooms[1,2] reveals a concentration of 83% adolescents (12 to 18), of which over half were for threatened or attempted suicide, this age group is at a high risk of repeated and more successful repetition, both due to being physically and intellectually more able than the six year old.[4] In both the child and adsolescent impulsivity is a real factor to be remembered. Suggestions for management:

- **Be comfortable with the subject.** Discussion does not aggravate the problem; nor does it prevent or precipitate suicide.

It is relieving to the patient, although not easy, to share secret thoughts.

- **Evaluate how serious the situation.** Every aspirin overdose is not necessarily ominous. It is important to sort out the manipulative elements, the nature of the interactional context, the child's strengths, the family strengths and resources.
- **Estimate the child or adolescent's capacity for lethal action**—for example: more severe with a 14 year old than a four old. Weapons, dangerous drugs should come under enquiry and care; direct supervision during agitation or impulsivity are important, particularly if such supervision is not being given by parents.
- **Child's relationship with the doctor is the core of treatment.** If there is trust, there will be sharing of the distress, and then possible changes may be made to improve the circumstances leading to the suicide threat or attempt.
- **Tell the child that since this is serious** —the information of suicide risk will have to be shared with parents, so that supervision and controls may be provided. Usually this brings relief to the child, and some insight to the parent.
- **Clearly express for the child or adolescent that the final responsibility for guardianship of his life is his own.** This is important, since it mobilizes the personality strengths of the child and attempts to encourage maturity and reduce impulsivity, which is a real danger in childhood and adolescence.

Homicidal Threat or Attempt

This emergency usually comes through pressure from neighbors or school authorities. However, there are times when it arises within the family, when a parent has been attacked by a child or adolescent.

Again, immediate professional concern is for good evaluation of the circumstances. See the child/adolescent alone first to get an estimate of his functioning, his mental status, his defenses, his strengths, his feeling of relatedness to others around him—family, school, other peers, authority, and with you, the examiner.

Then get a history to note how recurrent this behavior, how severe the intent or damage, the capacity of the child for further attempts. The family's tolerance for and modes of expression of anger is important to understand. Imitation is a learning mechanism, and the child may be repeating an often seen and heard pattern. Famitly treatment, rather than individual, may then be indicated. The doctor has to establish whether this is a serious problem requiring referral, or whether it is a transient phenomenon of some crisis, which can be discussed and resolved in one or two visits, and whether the acute agitation in the child may be alleviated by medication.

Physical Violence may become an emergency when there is sufficient harm to necessitate medical attention. When the violence is to the child, one may see a range from the "Battered Baby Syndrome", where there is recurrent trauma to an infant, to the adolescent who may be beaten by a drunken father. Action by the physician becomes of ethical concern where the child is unprotected from recurrence. Reporting the situation to Children and Family Service is encouraged when the parents deny responsibility or refuse referral for help from a Family Service agency or psychiatrist.[3]

When the child perpetrates the violence on self, other children, animals, or objects, this too may become an emergency. Self-mutilation may run from mild to severe, from nail-biting to sticking needles into muscles. Deliberate, recurrent harm to others will need to be evaluated in context, to establish its significance to the child as a means of expression, what his alternatives may be, and how ready the family is to look at and change behavior patterns. Covert or overt rejection of a child may lead to this form of retaliation and displacement. Working with parents is an essential part of the treatment. They may prefer to see this as "his" problem, but a change of thinking to "our" problem may bring desirable changes.

Experimentation with skills is part of the developmental process—testing muscles, fists and voice are all part of normal growth. Excess, uncontrolled expression of these newly-acquired motor strengths can become a problem.

Fire-setting with its resultant dramatic consequences is a problem that usually has no delay in emergency referral of child to physician and of expulsion of child from school. So, as a rule, there is the additional problem of getting the child back into the school system.

Discovery of the ability to make fire was an exciting advent to primitive man. It is still an adventure to each growing child, who will hap-

pily, sometimes fearfully, repeatedly turn on the gas range or light matches, in his attempt to gain control and mastery. The excitement of making bigger fires is noted in boy scout troops everywhere. Where there is control and no damage, no problem is noted. However, the child who burns a home down due to a "funfire" in the basement, or evacuates a whole school with a wastecan fire in the toilet, becomes a problem. Usually the event has already generated so much angry attention that the child is guarded, fearful and upset when he gets to the doctor, who should have a different role than the principal or fire-chief. Again, the doctor's task is to understand the patient, so that cause, prognosis, and course of treatment may be formulated. A simple experiment with accidental loss of control of the dangerous agent is very different from the child or adolsecent who has a history associated with numerous fires, where more is needed than brief therapy.

Where this is a first episode and the circumstances are considered by the doctor to be those where added limits and supervision by parents will be sufficient, then this may be comfortably handled, with occasional follow-up and a letter to the school to this effect. Where the physician has doubts about his own evaluation of the problem, then referral would be best.

Sexual "Emergencies" commonly bring children to physicians for rape or assault charges: to a girl or by a boy. The general alarm caused by sexual acting-out behavior is well known.[6] It is important to remember that, as with other aspects of growth, there is much learning and experimentation in process as the child develops awareness of body parts. What may give panic to certain inhibited adults, even professionals such as police officers, social workers and teachers, may be no more ominous than a facet of normal behavior not usually observed openly. Masturbation and sex play are aspects of normal sex growth. Certain children may be precocious physiologically or be from an environment where absence of privacy allows for viewing adult sexual activities without shame or restriction. The subcultural context has to be carefully considered in the total evaluation.

Any semblance of incestuous behavior may stir up neighbors, although many families will tolerate the activity within the home for long periods without seeking intervention. When such problems come to the physician in an emergency, it is his task to evaluate: a) the family interaction; b) the role played by the child and c) the emotional status of the child—how disturbed or accepting or conflicted or guilty.

Work needs to be done with parents to avoid histrionic handling and pressuring of the child to repeat the story over and over, which adds an element of exhibitionism to the event.

Exhibitionism by teenage boys is as old as man and occurs in the bushes of Africa and in men's rooms around the world, as the growing boy compares and comments. Inappropriate display of genitalia around girls' groups or in alleys needs to be evaluated. Possible retardation needs to be excluded, since this is not uncommonly associated with uninhibited masturbation or exhibitionism. In a boy of average intellect, the element of being dared by a group of watching youngsters makes this situation more a prank than a psychiatric symptom. However, in a solitary, anxious adolescent, especially where this is a recurrent practice, referral for psychiatric care is indicated and could assist him to improved adjustment.

Promiscuity in girls brings many an angry parent to a doctor in haste. "Is she pregnant?" "Does she have venereal disease?" are pertinent questions. Moral issues become increasingly the doctor's province as urbanization disrupts close ties with religious authority. Again here the total situation needs to be evaluated to understand the dynamics within the girl—her strengths, weaknesses, and defenses and the family interaction and resources. So, frequently the doctor will be ensnared into making the decision "should she abort or adopt?" The agony of indecision may be something the girl and parents *need* to endure, in order to achieve further growth and maturity in self-resolution, within the girl preferably, with respect and support from family and physician, whatever her final decision.

On occasion, neighbors will elicit intervention on behalf of a child when there is suspected prostitution in the home. Although this sounds sticky, the physician's role, as in the other cases, is to evaluate the child's functioning and whether his needs are being met. The child may be defensive related to fear of his being separated from a mother he may love and need. The doctor has to be very careful not become judge and executioner, but to stay objective in looking at the child.

Bizarre Behavior that is of sudden onset and non-understandable to the observer, will rapidly bring the child to a physician. Normalcy is de-

fined in terms of what is tolerated by the environment.

Today in adolescents, even in the 10-to-12-year age group, drugs become increasingly common as causative in toxic psychoses, and inquiry should always be made. Nor should alcohol be omitted as possibly a factor. Blood alcohol is easily estimated. One ten-year old was brought in for possible intracranial injury after falling from his bicycle. He was confused and had visual hallucinations. Blood alcohol was 116 mg%—he fell because he was intoxicated.

Severe anxiety in a child may distress both child and parent who seek emergency help. The real or imagined threat or danger may not become evident immediately, but within the supportive intimacy of the physician's office, with help to define the problem, to outline the symptoms, possible causes can be understood and sought together. Reassurance, clarification, perhaps medication briefly, symbolic of continued support, can greatly allay the panic and allow for the patient's own strengths and the family resources to assist in coping with the stress.

Anxiety may be expressed in crying, screaming, pacing, obsessive thoughts and activities, and a variety of mechanisms the child may use to handle the fears. A calm, reassuring, quiet yet firm adult is very important to the child's stability, and many times a tranquillizer for the mother does more for the child than anything else! The situation may be transient and well handled in this way. More chronic underlying pathology, with an acute episode seen, may require later referral.

Hysterical conversion symptoms such as sudden-onset hyperventilation, paralyses, mutism, etc., usually cause more anxiety in observer than patient, which can assist in diagnosis. Thorough examination, to rule out physical pathology, should be followed by calm, firm confrontation which differs from angry accusation of malingering. A statement that there is no physical problem, with interested concern for possible emotional factors, prevents chronicity of the behavior.[3] How the child handles (a) anger and (b) sexual impulses, are key questions in seeking etiology. The great majority of this type of emergency is and will continue to be seen and handled by the family physician.

The psychotic child is easily recognized since the responses are inappropriate, the capacity to relate to the examiner and to others is poor, usually the thought processes are markedly disturbed.[5] The phenothiazines form the bulwark of treatment for the psychoses, including children. The rapid chemical control achieved with intramuscular Thorazine brings relief to the patient, family and doctor, while sources of referral are sought.

Crises in key persons need to be recognized and dealt with by attempting to understand the antecedents of their own panic. Many a call for emergency help turns out to be not really in need of immediate contact, but has been going on for months. However, it is hard to evaluate on the phone when parent, social worker, teacher, policeman insists this is an emergency. Establishing family contact will give the true picture. Care should be taken to avoid manipulation into a "middle" position between coercive authority and defensive parent. Although endowed with magical powers by people of all ages, medical men need frequently to look down at their clay feet! There are certain situations which defeat our efforts, and such recognition early will avoid later over-driven efforts to rescue and intervene.

School phobia is especially mentioned since it is more common than most people realize. Also, with good *early* management, entrenchment of the problem is avoided, since the longer it persists the harder it is to treat. Giving medical slips to the school or requesting home tutoring is not uncommonly done by busy doctors under pressure from mothers. This is disastrous treatment. The child *must* return to school.

First, as before, see the child alone, then parents, *both* parents, to see where the family structure is weak. How much do the parents want or need the child home? Is the mother sick or depressed? What basic security is threatened in the child? Has mother said she will leave home and father, or vice versa? It there a new baby and the patient's dependency needs now neglected?

Then, having evaluated the situation, the doctor may need: a) to medicate the child if anxiety is high and/or b) to medicate mother or father or both if they are depressed or agitated. Whatever the situation, the child returns to school, while he receives support and a place to express himself after school. The parents will need the same, since no school phobia occurs in a vacuum.

The great majority settle with such brief intervention. A warning to parents that this may recur (a) after the child gets physically ill for a few days, (b) if parents are ill, (c) after long

weekends or vacations, will alert them to be firm and consistent and, if necessary, return for physician support at such times. A call to teacher for participation in the management plan of firm insistence that the child continue normal phase-related activity—namely school, is of great value in the total management.

Some cases of school phobia have a longer history and more complex pathology and may need referral. Hospital treatment may be the final course of management at which time intense family therapy should be administered.

Summary

The emergencies which frequently bring children and adolescents to doctors are discussed with general and specific management suggestions.

It is emphasized that, with a critical shortage of child psychiatrists and other service resources for troubled children, family physician and pediatricians deliver and will continue to deliver the greater and very important part of emergency services, both physical and psychiatric, to childrn and adolsecents.

Most of these crises have been well handled by family physicians and pediatricians as they become comfortable in defining the underlying problems and giving assistance to the key patient who at times is not the child.

Findings from the field of emergency work in child psychiatry,[1] suggest that criteria for effective resolution of the crisis include: (1) prompt evaluation of child and family; (2) clarifying for the family and child factors that provoked the emergency behavior; (3) active involvement of parents in a plan that gives specific and practical guidelines for immediate relief of the child's distress, i.e., protection, support, external controls; (4) access to a hospital facility for the very small number that need inpatient facilities; (5) access to an outpatient psychiatric facility for short-term therapy when indicated and (6) optimum use of special resources in the community such as school counselors, special education classrooms, Family Service Agencies, neighborhood Mental Health Clinics, sometimes juvenile officers and clergymen.

Recognition of problem areas beyond the physician's own comfortable management then allows rapid referral for further care to child and family. ◄

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Fewer Physicians

In the capitation system, payment is based on cost per capita. In the fee-for-service system, payment is based upon cost per service. In the salary system, the payment is based on income per doctor. Several alterations may be tried and their effect on the various parameters predicted. If the number of doctors is increased, there will be a simultaneous increase in the number of services rendered and possibly a decrease in the number of services per doctor. As the number of services per doctor decreases in a fee-for-service system, the physician's income will fall. This will inevitably justify an increase in price per service because experience in Canada shows that the public believes that physicians should be adequately compensated. The net effect of increasing the number of doctors will have been to increase both the price per service and the number of services per capita, thus leading to a multiplication type of increase in cost per capita.

Let us try the opposite—a decrease in the number of doctors. This will lead to a decrease in services per capita and maybe to an increase in services per doctor. As a result, there will be an increase in the physician's income and thus will reduce the pressure for an increase in price for service. Thus price per service will not increase, services per capita will decrease: the cost per capita must fall. Simultaneously, the income to the producer (doctor) increases and the cost to the consumer decreases. In the manufacturing industry changes of this nature are termed "an increase in productivity." (Baltzan, Mark A., M.D., "Canadian Health Care—The Saskatchewan Story," *The Internist,* Vol. XIII, No. 9, September 1972. p. 6.)

Gas Masks Permit Identification of Exhumed Corpse

By James D. Gross, M.D./Steator

Occasionally physicians are faced with the necessity to closely examine or perform an autopsy on a decomposed body. The strench emanating from such a body is often very severe and may be a factor favoring a cursory examination and failure to perform an autopsy. Such a course of action may in turn lead to suboptimal service to patients and to injustice. The following case of widespread interest in central Illinois illustrates this problem and the attendant results of failure to closely examine the body and to perform an autopsy. This case further demonstrates the manner in which the body was recovered, was thoroughly examined and was autopsied. Thorough examination and proper identification benefits to the deceased's family and to society are then briefly summarized.

Clinical Summary

An unidentified male corpse was discovered hanging by its neck in a secluded wooded area on October 4, 1970. The skin, underlying soft tissue and viscera were severly decomposed. The body had become separated into two parts. The head, neck, thorax and upper extremities were suspended from the tree, while the abdomen, pelvis and lower extremities were lying at the base of the tree.

The decaying, foul smelling body was examined by the County Coroner and was determined to be an unidentified 50-60 year-old Negro male. No autopsy was performed. No inquest was held prior to burial. The body was buried on October 5, 1970.

After the burial, the family of a man who had been missing since September 7, 1970, notified the County Sheriff's Department of their suspicion, based upon information released in local newspapers, that the unidentified corpse might be their missing relative, a 33-year-old white male.

Following prolonged legal procedures concerned with an exhumation of this nature, which was unprecedented in this county, a court order was obtained by the State's Attorney to exhume the body and to submit the remains to me for a thorough examination to definitely establish its identity. X-rays of a previous right femur fracture and dental X-rays taken of the missing man suspected of being the corpse were also sent to me for examination.

Upon receipt of the casket-enclosed body in the hospital autopsy suite, the stench was so great as to prevent personnel from coming within several feet of the casket. The odor readily permeated clothing at a considerable distance, making such clothing unsuitable for further wear. In order to overcome these obstacles all regular clothing was removed at a distance from the autopsy suite and surgical scrub suits, later to be incinerated, were donned by all personnel assisting with and witnessing the autopsy. A request for the use of several gas masks was made to the local civil defense unit. This organization helpfully responded with the loan of 6 U.S. Navy gas masks. The gas masks were placed into proper position over the faces of all who were to enter the autopsy suite. The effectively functioning gas masks completely eliminated the stench emanating from the body, permitting autopsy personnel to enter the autopsy suite, remove the body from the casket and bag and thoroughly examine the body, recover several pieces of physical evidence and to obtain tissue specimens and portable X-rays. Without the use of gas masks these procedures would not have been possible due to the incapacitating nausea precipitated by the severe stench.

Gross Autopsy

The body is that of a previously buried, markedly decomposed, white male. The body is in two pieces: one portion consists of the head,



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neck, upper extremities and thorax. The other portion consists of the abdomen, pelvis, and lower extremities. The scalp hair is long, black and straight. No teeth are found upon careful palpation of the maxilla and mandible. The flesh of many portions of the body, including the face, is markedly decomposed and absent in many areas. The skin of the protected areas of the body in the region of the lower legs appears partially preserved and appears to be white. In no area is skin resembling the deeply pigmented skin of a Negro found. The eyes are absent. Numerous maggots are found in this degenerating tissue. The neck is markedly decomposed and connects the head and thorax by only a 5 cm. wide band of tissue. The body is clothed in a blue jacket which is closed in the front by two safety pins. Beneath the jacket is a white T shirt. A thin belt is present in the blue pants. The body wears brown work shoes, two pairs of socks and undershorts beneath the blue pants. Within the right front pocket of the pants are a watch, 7 pennies, a piece of cylindrical metal and a pink comb. The watch had stopped at 9:25 on the hands and 4 on the calendar. A gold ring containing a rectangular red stone is present on the left ring finger.

The soft tissues of the body are completely degenerated and can not be examined satisfactorily. The thighs are dissected and the femora are exposed. The right femur in the middle third is found to be widened and irregular. There are numerous adhesions of the muscular and soft tissues around the thickened area of bone. There are also similar adhesions near the neck of the right femur. The left femur is without abnormality. The left femur in the middle one-third measures 3 x 3 cm., whereas the right femur in the middle one-third measures up to 5 x 5 cm. No other abnormality of the lower extremities is found.

Additional Studies

X-rays are taken of the femora in-situ and after removal from the thighs, X-rays are also taken of the skull, the maxilla and the mandible. No significant difference is found between the right femur fracture X-rays previously taken of the missing man and the right femur fracture X-rays taken of the exhumed body. The missing man is edentulous as is the exhumed body.

Microscopic study of the tissues is attempted but autolysis is so extreme that no significant additional information is obtained.

The brother and sister-in-law of the missing man suspected of being the corpse properly identified the ring and watch removed from the unidentified corpse. Other evidence contributing to the identification included testimony of witnesses who had observed the missing man's behavior just prior to his disappearance.

Conclusion

After compiling and analyzing all the available evidence the State's Attorney reached the only logical conclusion: the exhumed body was that of the missing man.

The concern regarding the identity of the previously unidentied corpse has been eliminated. The whereabouts and fate of the missing man have been established. Social Security and insurance benefits are now available to the family of the deceased. Thus ends the mystery of the unidentified corpse; the stench militating against thorough examination and proper identification of the corpse being overcome by the use of gas masks. ◄

Pediatric Perplexities

(Continued from page 347)

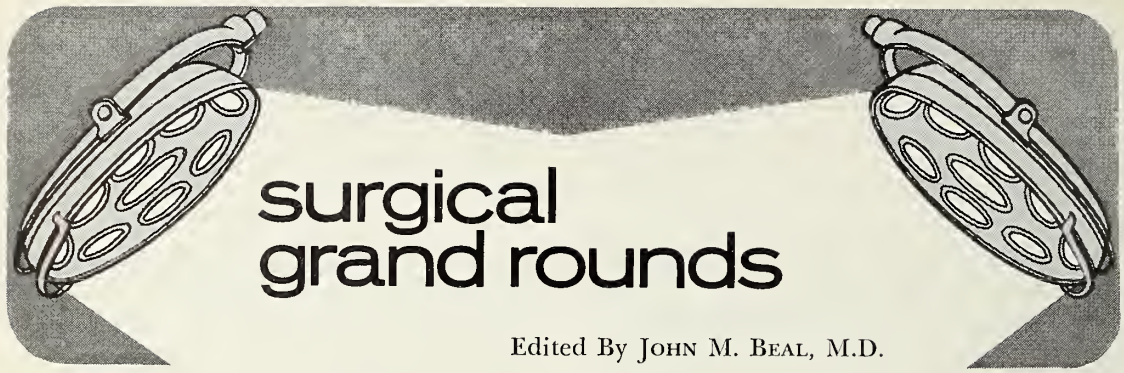
confused with those of neonatal hepatitis or biliary atresia. The regular presence of striking hepatomegaly, jaundice, and failure to gain weight is somewhat deceptive. Fever is not a striking finding in these desperately ill infants. The tip off comes in finding white cells or bacteria in the urine accompanied by an elevated BUN. In pure liver disease one would expect a normal or low BUN.

In 18 of the 22 instances, the infections were due to *E. coli,* the others being aerobacter arogenes, 2 paracolon and 1 mixed entrococci and aerobacter.

Thus, when one encounters a jaundiced infant with hepatomegaly one must add urinary tract infection to the usual differential diagnosis of biliary atresia and neonatal hepatitis. Failure to recognize this condition leads to a progressive septicemia and death when the condition is not promptly recognized and treated with antibiotics. ◄

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Edited By John M. Beal, M.D.

Ureteral Tumor

Surgical Grand Rounds are held weekly on Tuesday at 5:00 P.M. in the Offield Auditorium at Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial and the Veterans Administration Research Hospitals form the basis of the discussions. This case report was part of the Surgical Grand Rounds of September 28, 1971.

Case Report

Dr. Kenneth Simon: A 63-year-old white male entered the Veterans Administration Research Hospital with a chief complaint of total gross painless hematuria which had occurred six months before admission. He had not experienced subsequent episodes of hematuria during the intervening six months. Past medical history and systemic review were unremarkable. Physical examination was within normal limits except for fullness in the left flank at the time of palpation of the abdomen. Hemogram and chest X-ray examination were normal. Urinalysis revealed three red blood cells per high power field. Urine culture was later reported to be negative. An intravenous pyelogram was performed and the left kidney did not visualize. Therefore a retrograde bulb pyelogram was performed during the cystoscopy which did not show flow of urine from the left ureteral orifice.

Dr. Harold Matthies: There is a filling defect in the lower left ureter on retrograde examination. This most probably represents a tumor. Blood clot and/or stone are unlikely other possibilities. There was no visualization on the left side with excretory urography.

Dr. Kenneth Simon: Normal function was satisfactorily demonstrated in the opposite kidney. Two days later the patient was explored through the single incision used for nephroureterectomy for ureteral neoplasms. A hydronephrotic kidney and a firm mass in the lower ureter were found. The left kidney, ureter, and a 2 cm. cuff of bladder were removed.

Dr. Joseph C. Sherrick: Microscopic study of the ureteral tumor showed that it was a papillary tumor composed of delicate fronds of transitional epithelium, each with a thin fibrous connective tissue core. The epithelial cells were uniform in size and shape, and mitotic figures were rare (see figure 2). Fusion of the papillae was seen in many areas (see figure 3), and this finding is considered to be characteristic of malignancy. There was no evidence of invasion of the muscular wall of the ureter. The pathological diagnosis was well differentiated transitional carcinoma of the ureter.

Dr. Kenneth Simon: The post operative recovery period was uncomplicated. Incidence of various types of tumors in the kidney, renal pelvis, and ureter as reported from 3,000 pathology specimens showed that clear cell carcinoma or hypernephroma of the kidney comprised about 80%, and carcinoma of the pelvis of the kidney about 12%. The primary tumors of the ureter comprise approximately 1% of tumors of the upper urinary tract.

When hydronephrosis is encountered in men past 40 years of age, the possibility of obstruction from the tumor in the renal pelvis or ureter should always be considered, particularly if gross hematuria has been present. A discussion of epithelial tumors of the upper urinary tract must necessarily include both neoplasms of the renal



Figure 1 A and B. Film taken during retrograde pyelography demonstrates obstruction of lower portion of left ureter.

pelvis and ureter. Epithelial carcinoma is primarily a disease of the male with a sex distribution of 4 males to 1 female. There are two main types of epithelial carcinoma, transitional cell carcinoma and squamous cell carcinoma. The so-called benign papilloma is classified as a papilloma transitional cell carcinoma grade one. It should be emphasized that the term papillary is a microscopic rather than a gross description. The tumors that may appear solid on gross examination may be papillary on miscroscopic examination.

Papillary noninfiltrating tumors have the most-favorable prognosis. Approximately 80-85% of upper urinary tract epithelial tumors are papillary and only 40% of the papillary tumors are infiltrative. Comparison of the papillary and nonpapillary tumors of renal pelvis and ureter shows that the incidence of papillary invasive and papillary noninvasive tumors of the renal pelvis are about equal while the ratio of papillary noninfiltrating to infiltrating tumors of the ureter is about 2 to 1. Papillary tumors have a distinct tendency to be multiple and in one series comprised more than 40%, whereas nonpapillary or solid tumors are usually single lesions. When tumors are solitary or single, the renal pelvis is involved more than twice as frequently as the ureter.

When multiple papillary tumors involve both the pelvis and the ureter, in the past, the lesion of the pelvis has been considered to be the primary lesion, and the ureteral lesion a seconddary lesion. This assumption is not considered valid and multicentric origin is now considered more likely. Therefore when an epithelial tumor is encountered in the renal pelvis, ureter, or bladder, the entire urinary tract must be visualized by endoscopic and radiologic methods. Too often a papillary tumor of the bladder is treated for months or years only to discover a primary lesion in the renal pelvis or ureter which has progressed to the point of inoperability. This is reflected in the statistics in both British and American studies showing a one to six month delay in about 60% of the patients with epithelial tumors of the upper urinary tract, the most common cause of delay being the presence of the bladder tumor.

Unlike many conditions, the difficulty of diagnosis is not due to the various modes of presentation because all patients in several of the studies complained of hematuria when first seen and about 20% experienced flank pain from associated hydronephrosis. The clinical symptoms of both renal pelvis and ureteral neoplasms are similar and include gross hematuria, flank pain, and a flank mass. Diagnostically, the pathologic



Figure 2. Microscopic study demonstrated transitional cell epithelium with uniform cellular structure.

X-ray findings include a negative filling defect in the renal pelvis or ureter. Differential diagnosis must include blood clots, radiolucent calculi, and extrinsic tumors which have invaded the renal pelvis. In the case of papillary tumors, the defect may be irregular. In some cases, calcification in the tumor may be detected on the plain film of the abdomen and be mistaken for a calculus. The diagnostic accuracy of primary ureteral neoplasms is the poorest for any ureteral lesion. The ureter seldom fills completely with contrast media during intravenous pyelography and failure of visualization is too often dismissed as lacking in significance. The use of the bulb retrograde pyelogram has been helpful in obtaining complete filling of the collective system. When a ureteral neoplasm is present, the retrograde catheter tends to coil in the dilated area immediately below the tumor.

The treatment of choice for both renal pelvis and ureteral neoplasm of transitional epithelia is total nephroureterectomy. The kidney and entire ureter should be removed with a cuff of adjacent bladder to insure completeness of excision. Recurrent tumor in the ureteral stump after nephroureterectomy has been reported and suggests that many surgeons do not remove the entire lower ureteral segment. This segment of ureter is frequently difficult to expose, particularly in the male pelvis. We have found that a single incision affords excellent exposure even in obese patients and reduces the operating time as well as the post-operative morbidity.

Prognosis may be correlated with the histologic grading of both tumors in the renal pelvis and the ureter. The results of nephroureterectomy in the undifferentiated tumors has been very disappointing with infiltration beyond the ureteral wall.

Dr. John Beal: Dr. Grayhack, do you have any comments?

Dr. John T. Grayhack: Adequate visualization of the entire urinary tract is important to diagnosis of these tumors early. As has been pointed out, the retrograde bulb pyeloureterogram is often essential to accomplish this. Urinary cytology is also likely to be informative. Use of a brush or even a stone basket to obtain tissue has been utilized successfully on occasion.

The incidence of transitional cell neoplasm seems to be increasing. These tumors are of special interest because they have recognized association with exposure in the dye and rubber industry. The incidence is higher in smokers than in non-smokers. A recent study has also indicated a higher incidence in coffee drinkers although the evidence presented is not very convincing. Some investigators are trying to implicate the metabolites of tryptophan in induction of these neoplasms. Of special importance is the fact that use of agents such as beta naphtholmine will allow induction of a tumor in animals which corresponds in histologic and biologic characteristics to that seen in man. This seems to offer a seemingly ideal opportunity for a search for effective chemotherapeutic agents.

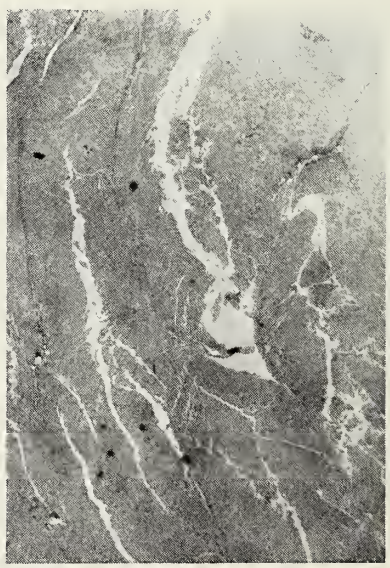


Figure 3. Fusion of papillae indicates malignant characteristics of this ureteral tumor.

Dr. John Beal: Dr. Grayhack, a couple of questions. I can understand that if you have a papillary tumor in the pelvis or kidney you need to take out the entire upper tract, but here was a papillary tumor in the lower ureter.

Dr. John Grayhack: In this patient we did not know if the upper tract was involved or not, since it could not be adequately visualized pre-operatively. At times there will be a small lesion in the renal pelvis associated with a large ureteral or bladder lesion. In this patient, the functional status of the kidney was certainly questionable. If the ureteral tumor is apparently single, low grade, and not infiltrating, there are those who advocate local excision. I have done that in poor risk patients with some impairment of renal function. To date, the few results reported for selected local excision have been satisfactory but the key has been selection. If this procedure is carried out in large numbers of patients with less differentiated or infiltrating tumors, a high recurrence rate would be probable.

Urothelial tumors do tend to be present in multiple areas which often require histologic study to permit recognition. For instance, the incidence of unsuspected neoplastic involvement of a lower ureter in patients undergoing cystectomy for bladder tumors is over 15%. **The treatment of choice to eradicate the neoplasm when a renal pelvic or ureteral tumor is present is nephroureterectomy with excision of an adjacent cuff of bladder.** Generally, my preference is to expose the portion of the urinary tract with the lesion and establish the diagnosis. Opening the urinary tract to inspect the questionable lesion is reasonable, but meticulous care to prevent spill and local wound contamination is necessary. Both the single and double incision are used by us. The key to the single incision described by Dr. V. J. O'Conor, Jr., is the use of a racquet type of bladder incision similar to that employed in correction of vesico vaginal fistula. Early occlusion of the inferior portion of the ureter to prevent tumor contamination of the lower urinary tract is important.

Dr. John Beal: Isn't there a new pyeloureteroscope available to look at the upper collecting system?

Dr. John Grayhack: Yes, but it is still in the experimental stage. At the moment we have no personal experience with it but it should be of considerable assistance in identifying and treating a variety of lesions of the ureter and renal collecting systems. ◄

Immediate Transfusion Reaction

(Continued from page 352)

and penetrating wound of heart, pulmonary hilus, aorta or vena cava are a few examples of the type of disease in which the highly questionable practice of using non-crossmatched blood has been continued up to the present time.

However, when such an instance is encountered, the basic priciple must be borne in mind that blood volume replacement with *any* type of fluid is the first order of business. Whole blood has only two major pharmacological properties: volume expansion and increase in oxygen carrying capacity (red cell mass). Of these two, volume expansion is infinitely more important initially; obviously after a short time (usually 30-60 minutes), resuscitative efforts also require red cell transfusion, but appropriately typed and crossmatched blood should always be available within that time. This principle is re-enforced by the ready availability of 10% dextran (standard clinical dextran, mean molecular weight 75,000) or 6% serum albumin solutions. Such colloids are excellent volume expanders, are readily available in the Emergency Room, and have rendered obsolete the "universal donor" transfusion practice.

Summary

Immediate transfusion reactions are dramatic, frequently frightening to both patient and physician, and require immediate differentiation with appropriate treatment. A review of basic transfusional practice and familiarization with the essentials of these reactions should be required of all physicians treating acutely ill or injured patients. Emerging from such review will be a definite trend to fewer transfusions of red cell containing fluids, and a greater reliance on other colloids for acute volume replacement. In addition, fewer patients with anemia or chronic debilitating disease will be transfused as oral and intravenous hyperalimentation assume their proper place in the physician's armamentarium. ◄

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Guided Non-Visualized Nasal Endotracheal Intubation Using a Transtracheal Fogarty Catheter

By Russell R. Carlson, M.D. and Max S. Sadove, M.D./Chicago

Endotracheal intubation, where direct laryngoscopy is precluded by anatomical, pathological, or mechanical obstacles, or is indicated by surgical considerations, is often performed by "blind" nasal tracheal intubation.[1,2] It is unusual that this cannot be performed with relative ease. It can be done safely under sedation without obtunding the patient to a dangerous degree, while preserving patient cooperation and usually complete amnesia of the intubation procedure. And it can be done, although less frequently, without movement of the head and neck. If possible, mechanical restrictions, such as cervical traction, body casts, halo-pelvic hoops, and jaw wiring should be readily removable if the life of the patient becomes endangered during intubation or the induction of anesthesia.

In especially difficult cases of "blind" nasal tracheal intubation, several facilitating techniques have been utilized. One, described by Bearman,[3] utilizes a wire hook placed in the visual oral pharynx to guide the distal end of the endotracheal tube into an anterior larynx. This method is efficacious where the epiglottis or larynx may be partially visualized or evidenced by the effect of exhalation on the movement of mucous in the pharynx. A Magill forceps may be similarly utilized to place an errant tube in the midline or anteriorly.[4]

A second technique, described by Waters,[5] utilizes a transtracheal vinyl tube which is passed retrograde to the nares and which then serves as a guide for the nasal endotracheal tube. As Waters suggests, the endotracheal tube must not be too large in diameter for it will hang-up on the rima glottis. This may happen on occasion with this technique and, in addition, considerable tension on the catheter must at times be used to direct the tube to the laryngeal opening.

The present method utilizes a transtracheal Fogarty catheter as a guide to direct the end of the nasal endotracheal tube readily to the laryngeal opening. Fogarty catheters may sometimes be used only once by the surgical service, but they may be resterilized and therefore be available and useful for the anesthesiologist.

Method

Patients in whom a difficult intubation is anticipated are appropriately premedicated and then brought to the operating room where an intravenous route is established. Further sedation is then accomplished by "titrating" intravenous agents, such as narcotic-tranquilizer combinations to the point where the patient is cooperative but rather heavily sedated. Topical anesthesia of the nares and oral pharynx is applied with 1-2% tetracaine and 1% Ephedrine spray. The patency of the nares is assessed by occluding each nostril. A lubricated sterile nasal endotracheal tube is inserted to the area of the larynx, where topical anesthetic is then applied during inspiration to the larynx and trachea by spraying through the endotracheal tube sometimes with encouragement for a deep breath. Attempts at intubation are then performed prior to the use of a transtracheal guide. In the event these are unsuccessful, the anterior aspect of the neck is surgically prepped and draped. A skin wheal is raised and the anesthetic solution is advanced through the subcutaneous tissues into the tracheal lumen.

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A standard intravenous extracath is then inserted into the trachea with the short-beveled needle opening directed cephalad. In the case of 14 gauge cannula, a #4 Fogarty catheter is then inserted through the plastic cannula and passed retrograde through the larynx into the mouth or pharynx, where it is grasped with forceps. Smaller cannulae and Fogarty catheters may be used. A standard suction catheter is then passed through the nose and similarly brought out of the mouth. The Fogarty catheter is placed in the suction catheter tip and the suction catheter withdrawn through the nose. The balloon of the Fogarty catheter, previously tested, is inflated in the tracheal end of the nasal endotracheal tube. The endotracheal tube is advanced to the area of the larynx where guidance is now needed. Gentle traction is placed on the Fogarty catheter to guide the tip of the endotracheal tube into the laryngeal opening. The Fogarty catheter cannot be used to pull the endotracheal tube from the nose into the trachea. When breath sounds are occluded, the Fogarty catheter balloon is deflated and the catheter withdrawn through the extracath. The extracath is finally withdrawn and the endotracheal tube advanced. The presence of the endotracheal tube in the trachea, as in any intubation, must be carefully ascertained by auscultation, examination of the chest, and flow of air through the tube.

Case Presentation

The patient was a 21-year-old, 106 pound female, admitted for the 17th time to the University of Illinois Hospitals. She had the problem of severe postpolio paralytic scoliosis. Her medical history included numerous surgeries for correction of her spinal column deformity, including posterior fusion, repair of pseudoarthrosis, osteotomies, insertion of a Harrington rod, and removal of a bursa about the Harrington rod.

Her first surgery of the present series was on April 14, 1970, and was for the initial application of a halo-pelvic hoop, a device fixing the head, neck, back and pelvis of the patient, and capable of being used to distract the scoliotic spinal column. A nasal endotracheal intubation was performed under direct laryngoscopy, with the patient anesthetized, and without difficulty. In this instance the nasal tube was placed for the purpose of maintaining the airway postoperatively, when the patient's head, neck, spine, and pelvis would be in a fixed position and where subsequent intubation might be extremely difficult should the need arise. When fully awake, and with adequate tidal volume assessed by measurement, the patient was uneventfully intubated.

The patient's second surgery, on April 20, 1970, was performed for spinal osteotomy. The patient was premedicated on the ward with meperidine 50 mgm. and Scopolamine 0.4 mgm., and brought to the operating room fixed in a distracted position in the halo-pelvic hoop. Additional sedation with 4 cc Innovar was given slowly over a 15 minute period, producing a state of sensorial "blunting," while maintaining adequate ventilation and patient cooperation. Topical anesthesia of the nares, oral pharynx, tongue, lips, and trachea were accomplished with 2% tetracaine and 1% Ephedrine. The nasal endotracheal tube was inserted "blindly" with difficulty, necessitating placement of the tube in the midline and anteriorly by use of a Magill forceps in the visualized portion of the oral pharynx. Only a small portion of the tube could be seen and the epiglottis was not visualized. Extubation postoperatively with the patient awake in the recovery room was without incident.

The patient's third surgery of this admission was performed on May 19, 1970, again with the patient distracted in the halo-pelvic hoop, for a fibular graft to postoperative osteotomy sites. The patient's premedication on the ward was meperidine 50 mgm., diazepam 10 mgm. and Atropine 0.4 mgm.

In the operating room, an additional 70 mgm. of meperidine and 12.5 mgm. of diazepam were given over a 45 minute period. After topical anesthesia, nasal endotracheal intubation was attempted blindly, and after numerous attempts this method was abandoned. A Fogarty catheter was inserted transtracheal and brought out through the nose where the balloon was then inflated in the tip of the endotracheal tube. The tube was then guided with ease into the trachea. Postoperatively the patient was extubated when awake in the recovery room without incident.

It is important to note, from the standpoint of patient and physician acceptance of the technique, that the patient had no recall of the attempts at intubation. She experienced no significant pharyngitis or laryngitis postoperatively. Her recall of the endotracheal tube was limited to the recovery room where, "It was not uncomfortable, but it was good to get it out."

(Continued on page 368)

Enigmatic Fever During Hemodialysis

By Alton J. Morris M.D., and Richard T. Bilinsky, M.D./Springfield

Intermittent extracorporeal hemodialysis is frequently used as a therapeutic procedure, yet there have been few reports of untoward reactions as a result of bacterial contamination of the dialysate fluid. Murray et al.,[1] using Kiil dialyzers, indicated that bacterial growth can occur in the fluid, but minimized its clinical significance in the absence of a defect in the dialytic membrane. The British Public Health Laboratory Service Report on Infection Risks of Hemodialysis briefly alludes to this problem and makes vague recommendations as to its control.[2] The present report describes the occurrence of severe febrile reactions in four patients undergoing extracorporeal hemodialysis. The hyperpyrexia was presumably a result of pyrogens absorbed from dialysate grossly contaminated with Pseudomonas aeruginosa.

Description

During 1969, the (Springfield) Memorial Hospital Renal Unit utilized 6 Travenol RSP Hemodialyzers which were operated by nurses and technicians under physician supervision. The procedure was accomplished in the standard manner, employing Travenol Dialysate Bath Concentrate diluted with tap water to constitute the bath. The dialysate was mixed individually for each machine in the morning, and at the conclusion of the dialysis the machine was cleaned with a detergent, rinsed with tap water, and drained. Once each week the dialyzer was rinsed with formalin for 30 minutes and then drained. In the past, routine bacteriological cultures of the apparatus had not been taken. Bacterial cultures of the water supply were taken at intervals and were negative.

During the first year of the Renal Unit's operation, clinical problems due to contaminated dialysis equipment were not apparent. Strict sterile technique was observed during all shunt manipulation and venipunctures. Febrile patients were dialyzed, but on each occasion the etiology of the fever was known and was not related to the procedure. Blood transfusions were used infrequently and were not accompanied by pyrogenic reactions.

During a two week period from April 25th to May 8th, 1969, 55 hemodialyses were performed in this Unit. On four occasions, patients developed chills and fever during dialysis.

Report of Cases

Case 1: This 54-year-old man with polycystic renal disease had undergone 54 hemodialyses since August, 1968 without incident. On April 25th the patient was being dialyzed via a subcutaneous A-V fistula. Four hours after the start of dialysis he developed shaking chills and fever, spiking rapidly to 104.2°F. There were no other symptoms, and physical examination was unremarkable. A blood culture taken at the time of the rigor subsequently revealed "no growth." The dialysis was terminated at the time of the temperature spike and the patient was kept under observation. His only medication was a salicylate, and his temperature fell to normal within eight hours. There was no recurrence of the febrile pattern. The dialysate was not cultured.

Case 2: This 30-year-old woman with chronic glomerulonephritis was transferred to Memorial Hospital in July, 1968. She subsequently had 97 hemodialyses without any febrile reaction. On April 28th, her hemodialysis was started, utiliz-

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RICHARD T. BILINSKY, M.D., Springfield, is the Director of the Renal Unit, Memorial Hospital. Dr. Bilinsky is a Clinical Assistant Professor in the Department of Medicine at Southern Illinois University School of Medicine. He is an attending physician in the Division of Medicine at Memorial Hospital and, attending physician and Consultant in Nephrology at St. Johns Hospital. He is a graduate of the Chicago Medical School.

ing her A-V fistula. Six hours later she suddenly developed chills and fever, spiking to 103.8°F. There were no other complaints and the physical examination was unremarkable. With the administration of salicylates, the temperature decreased within six hours and the patient remained afebrile. A blood culture taken at the time of the rigors revealed "no growth." The dialysate was not cultured.

Case 3: This 27-year-old man with chronic glomerulonephritis had undergone 83 hemodialyses since his entrance into the program in June, 1968. On April 29th, he was hemodialyzed for six hours without incident. Within minutes after the termination of dialysis, he developed severe chills and fever, spiking to 104.2°F. The dialysate was not cultured. He was treated only with salicylates and over the course of the ensuing six hours, the temperature decreased to normal. Physical examination was unremarkable, and a blood culture taken during the height of the febrile response was subsequently reported as "no growth."

Case 4: This 36-year-old woman had chronic pyelonephritis in a solitary kidney which was drained by a permanent nephrostomy. Following her transfer to this facility in May, 1968, she had 55 hemodialyses without complication. On May 8th, 1969, 4½ hours after the start of dialysis, the patient became nauseated and rapidly developed chills and fever. Her temperature spiked to 103.2°F and, in spite of salicylates, remained elevated for six hours. A blood culture was negative and there was no impairment of the nephrostomy drainage or acute exacerbation of renal infection at that site.

At the time this last patient became ill, the dialysis technician detected a strong putrid odor emanating from the dialyzing compartment of the machine. A similar, but milder, odor was noticed in the dialyzing compartments of two other machines, and the dialysate in all three appeared somewhat cloudy. The solution in the fluid reservoir tank of each of the dialyzers was clear and odorless. Dialysis was immediately stopped for all three patients, although only one patient (Case 4) was febrile. Bacteriologic specimens were taken from both the dialyzing compartments and the reservoir tanks of each of the three machines. A heavy confluent growth of Pseudomonas aeruginosa was obtained from the dialysate in the dialyzing compartment of all three, whereas cultures of the reservoir tank fluid revealed only a sparse growth of B. subtilis, E. coli, and/or Klebsiella-enterobacter. This would suggest that the source of the contamination was the pump apparatus and conduits between the reservoir and the dialyzing compartment.

Cleaning methods in this unit were immediately modified. The machines have since been cleaned with bleach and stored with hypertonic saline solution. Once each week they are stored overnight with 4% formalin in the conduit circuit. No subsequent febrile episodes have occurred. Serial bacteriological surveys have revealed no growth in most instances and scant growth of Proteus or Serratia on a few occasions.

Discussion

The occurrence of bacterial innoculation of the dialysis bath should be of great concern. This fluid contains glucose and electrolytes in physiologic concentrations, and although rapid flow rates and the mechanism of recirculating single pass eliminates excessive accumulation of nitrogenous waste, enough is present in the fluid to make it an excellent culture medium.[3] In addition, the heating of the fluid to 37°C and the interval between the preparation of the dialysis bath and the start of dialysis also serve to facilitate bacterial multiplication.

If the pumps and conduits between the reservoir tank and the dialyzing compartment are heavily contaminated with micro-organisms, continuous inoculation of dialysate in transit occurs. Within the dialyzing compartment, the fluid is constantly being replenished, so in effect a continuous innoculation of dialysate in transit occurs. Within the dialyzing compartment, the fluid is constantly being replenished, so in effect a continuous charge culture is established. Under such circumstances, bacteria remain in the exponential growth phase without exhausting the "medium," and this results in innumerable bacteria and a high concentration of bacterial metabolites. Although the coil membrane serves as an effective barrier to bacteria, it is not impervious to low molecular weight products of bacterial metabolism. Kidd[4] has shown that bacteria do multiply in dialysate, that metabolic products are detectable in the fluid, and that pyocyanin, indole, hemolysin, and other substances pass across the cellophane membrane. In the present series, it seems unlikely that viable bacteria entered the circulation from the dialysate to cause a short, self-limited, febrile illness. Rather, the "infection" was extracorporeal in the

dialysate, with bacterial pyrogens passing through the membrane to enter the blood.

All hemodialysis facilitates using recirculating single pass machines should employ proper bacteriologic safeguards to insure against gross contamination of dialysate. The reservoir tank and dialyzing compartment are accessible and easily cleaned and dried; however, the pumps and conduit tubes are unfortunately difficult to clean, drain or inspect. Our RSP Hemodialyzers were checked on several occasions for fluid remaining in conduits following complete draining by the drain pump and the manual drain. The recovery of residual fluid was accomplished by disconnecting the tubing between the drain pump and the reservoir drain. An average of 275 ml. of dialysate was recovered from this conduit system by the procedure described. An additional source of remaining fluid, much smaller in amount, was found in the tubing between the flow meter and the dialyzing compartment. The average fluid recovered in this tubing was 27 ml. Ideally, hemodialysis machines should be designed so that all parts can be readily drained, disinfected and dried. Instructions should be issued regarding cleaning procedures which are effective, yet not injurious to the equipment. Methods of disinfection should be periodically reviewed and checked by appropriate laboratory techniques.

Summary

Between April 25th and May 8th, 1969, 55 hemodialyses were performed in the Springfield Memorial Hospital Renal Unit. Of these, four were complicated by the acute onset of chills and fever. A bacteriological survey indicated that three hemodialysis machines were heavily contaminated with Pseudomonas aeruginosa. Presumably the hyperpyrexic episodes were due to absorption of bacterial pyrogens from the dialysate through the dialyzing membrane. ◄

Reference

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Guided Non-Visualized Nasal Endotracheal Intubation

(Continued from page 364)

Discussion

The case history illustrates several aspects of nasal endotracheal intubation. What is an easy intubation in a particular patient may, on a return visit to the operating room when the patient is encumbered with restrictive apparatus, become a most difficult intubation requiring an armamentarium of skills and apparatus. It should be noted that a variety of intravenous agents or gaseous anesthetics, e.g., Penthrane,® Valium,® Innovar,® Droperidol etc., may be used to "blunt" a patient while preserving cooperation during application of topical anesthesia and attempts at intubation. Each patient must be individualized or "titrated" with special attention to the adequacy of respiration versus sedation.

The present method is just a variation of Waters' technique. For cases of extraordinary difficulty in intubation, usually associated with restrictive apparatus which fixes the patient's head and neck, it utilizes the balloon of the Fogarty catheter to guide the tip of the endotracheal tube and utilizes simple equipment available in most operating rooms. ◄

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Highlights of the

133rd ISMS Annual Meeting

in the May IMJ

report

a service of the american association of medical assistants, illinois society

News from Illinois Society of AAMA and County Chapters Directory

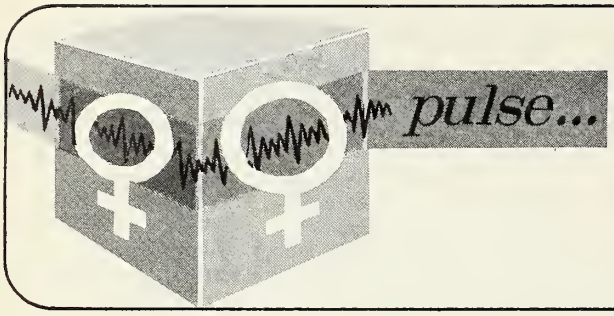
Illinois Society of AAMA has been in existence since 1957. Adams, Sangamon, and Cook (Chicago) Counties were among the forerunners of today's strong society offering continual educational opportunities to individual members as well as counties. Speaking, listening, learning seminars and symposiums are but a few of the many means employed to alert today's medical assistant and up-date her methods and procedures.

The Annual meeting and Convention will be at the Pheasant Run Lodge in St. Charles the week-end of April 27 to 29. The program is designed to attract medical assistants from all over Illinois. The theme is "Tomorrow's Galaxy."

If you are interested in more information on the medical assistant's program, the location of Illinois Society County Chapters are listed below, along with the presiding officers. Please feel free to contact these people:

Northwest Cook	Mrs. Jean Nelson, 829 Carnby Ct., Schaumburg, 60172
South Cook	Miss Ceil Kenney, 11750 South Homan Ave., Marionette Park
De Kalb	Mrs. Corinne Berg, 720 Cloverlane, Sycamore, 60178
DuPage	Miss Phyllis Vogt, 417 East Evergreen, Wheaton, 60187
Iroquois	Mrs. Jean Wilkinson, R.R. #1, Sheldon, 60966
Jefferson-Hamilton	Mrs. Jean Anthony, 1009 Pace Street, Mount Vernon
Kane	Miss Ina Yenerich, 839 Jefferson St., Elgin, 60120
Lake	Mrs. Jessie Ogle, 1303 North Sheridan, Waukegan, 60085
Kankakee	Mrs. June Yeates, 471 South Dearborn, Kankakee, 60901
Knox	Miss Mary Bradford, 164 North Broad St., Galesburg, 61401
La Salle	Mrs. Nancy Porter, 719 6th St., LaSalle, 61301
Little Egypt	Mrs. Beverly Barrett, R.R. #8, Carbondale
Macon	Mrs. Ruby Agnew, 1066 Oakcrest St., Decatur, 62522
McLean	Miss Jane Hornstein, 2010 East Empire, Bloomington, 61701
McHenry	Mrs. Doris Meyer, 1308 Queen Anne St., Woodstock, 60098
Morgan-Scott	Mrs. Norma Gunnels, 405 East Laurel Ave., Jacksonville
Peoria	Mrs. Margaret Jurick, 1611 N. Delaware, Peoria, 61603
Rock Island	Mrs. Penny Knaack, 3336—41st St., Moline, 62165
Sangamon	Mrs. Doris Fehring, 2022 N. Elizabeth, Springfield, 62702
Spoon River	Mrs. Mary Louise Wilson, 255 Central St., Farmington, 61531
St. Clair	Mrs. JoAnn Ridgeway, 216 Mimosa Ave., Bellevilie, 62221
Stephenson	Mrs. Shirley Hoeffle, 436 West Garfield, Freeport, 61032
Tazewell	Mrs. Verla Gay, 1000 Lincoln Ave., Pekin, 61554
Vermilion	Mrs. Yvonne K. Holden, 416 Dawne Ave., Danville, 61832
Will-Grundy	Mrs. Joan Dearth, 980 Mazon St., Coal City, 60416

The President of The Illinois Society is Mrs. June Hall, 1217 Sheridan St., Danville, 61832



pulse... of the doctor's wife

Mrs. Robert Hart, Editor

To The Stars Through Your Aspirations

In developing a theme for the Woman's Auxiliary year, 1973-74, we have chosen a Latin phrase, *Ad Astra Per Aspera*; and although the connotation is that of lofty goals too difficult to reach, there are practical ways of accomplishing our aspirations.

Fifty years have passed since the first Woman's Auxiliary to the American Medical Association was formed; 50 years of accomplishment and achievement in the fast and ever-changing face of medicine. Many of our ideals remain the same and stand firm and unfailing throughout the bombardment of changing times on our mores. The first 50 years have brought us to heights of genuine, humanitarian concern for all peoples, to efforts directed toward improving the quality of life of every person, from conception to the grave. But we have NOT fulfilled our dreams; we must survey the steps to be taken in order to meet the challenges which lie ahead for the next 50 years.

Let us direct our thoughts and our actions, then, toward reaching our stars. Let us aspire with a dedication and enthusiasm which will put all other aspirations in the background toward achieving for medicine star-steps along the way toward unknown but conquerable obstacles.

We will train out sights into focus on a practical level and attempt to move logically toward achievement of our aims. We will each have personal goals, the county auxiliaries will have their goals, and the state board will have its goals. The first star-step to take is *to analyze*. An auxiliary member who carries any role of responsibility is going to have personal goals which are to be reached by self-analysis and job analysis. The auxiliary is going to analyze the individuals within the group, the group as a whole, and the community in which the auxiliary is working in order to reach a decision on goals. And the state board, which is dedicated to the responsibility of directing, educating, implementing, coordinating, and amelioriating, will choose its goals accordingly, following careful analysis of its structure, duties, and capabilities.

The second step, *the choosing of a goal or goals,* is followed by step three, *charting the course*. Charting involves monthly, progressive plans for accomplishment. County presidents and board members have been given a "How to" and "Who" Manual which contains monthly calendars and spaces for monthly goals for easier charting.

The hub of the plan involves step four—ACTION, the actual doing for accomplishment. In order to reach our constellation (to the stars through your aspirations), which can be called "Illinois," we are going to use the following tools;

Communicate—communicate with each other in your auxiliaries and in your communities.

Organize—thoroughly planning the task and delegating portions of it using the four "W's"—Who, What Where and When —will bring achievement.

Negate—the negative and accentuate the positive.

Seek—out others, broadening our horizons and capabilities.

Trigger—motivate!

Enthuse—enthusiasm is contagious and fires up interest in the task.

Laugh—lightens the load by seeing the humor in situations when business becomes too serious.

Labor—any worthwhile project requires hard work and through labor success will come about.

Allow—understanding of each individual and her needs and talents contributes to the democratic accomplishment of the job to be done.

Train—education and knowledge of problems, projects, and resources available is a boon, a necessity, in fact, for reaching good results.

Innovate—to innovate we must weave together continuity and change and be alert to flexible ways in which to discern change so that we will be renewed.

Officiate—a responsibility for our tasks and office, and the ability to direct the work to be done is also necessary.

Negate—to repeat, to allow no negativism will eliminate indifference and build enthusiasm for the year's work in 1973-74.

Assuming your action tools have led to accomplishment and end results, step five involves *an evaluation of your efforts.* Using the original analysis of the need, an evaluation will be your final key to success and a guide in working through future goals. As Robert A. Millikan said: "We have come from somewhere and we are going somewhere. The great architect of the universe never built a stairway that leads to nowhere."

As physicians' wives in Illinois we have a destiny to fulfill. Our state is the hub of medical knowledge and accomplishment in the United States and possibly the world. Are we going to live up to our heritage and the power of our destiny to be leaders in every aspect of health care, health education, and legislative influence which we have the opportunity to exert?

Thank you for your confidence in me. I am confident in you, also. I hereby make my personal commitment to you for 1973-74:

"I, Beatrice Hartman, will devote and direct my energies during the coming year in the Woman's Auxiliary to the Illinois State Medical Society and the American Medical Association toward performing those steps necessary to carrying forward our destiny as the supporting "right side of the Caduceus."

May I share this poem with you? It was written by Florence Earle Coates.

Per Aspera

Thank God, a man can grow!
He is not bound
With earthward gaze to creep along the ground:
Though his beginnings be but poor and low.
Thank God, a man can grow!
The fire upon his altars may burn dim,
The torch he lighted may in darkness fail,
And nothing to rekindle it avail.
Yet high beyond his dull horizon's rim,
Arcturus and the Pleiades beckon him.

Will you answer the beckoning with me . . .? ◄

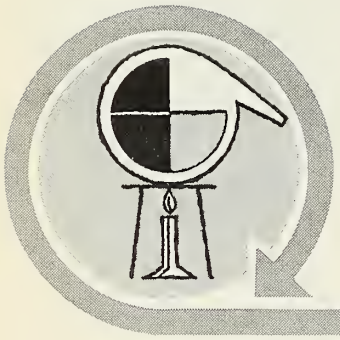
Beatrice Hartman
1973-74 President,
WA/ISMS

Mrs. Martinucci Honored



Mrs. August (Livia) Martinucci, 1972 President of the WA/ISMS, displays the resolutions read before the Seventy-seventh General Assembly of the State of Illinois which paid tribute to her for her contributions and efforts on behalf of medical welfare in Illinois.

Representatives George O'Brien, Robert Blair and John Houlihan offered House Resolution No. 559 and Senator Mead Baltz offered Senate Resolution 366 which honored Mrs. Martinucci.



new pharmaceutical specialties

By Paul Dehaen

For detailed information regarding indications, dosage, contraindications and adverse reactions; refer to the manufacturer's package insert or brochure.

Single Chemicals—Drugs not previously known, including new salts.

Duplicate Single Drugs—Drugs marketed by more than one manufacturer.

Combination Products—Drugs consisting of two or more active ingredients.

New Dosage Forms—Of a previously introduced product.

The following new drugs have been marketed:

SINGLE CHEMICALS

ABEREL	Vitamin A Acid	Rx
Manufacturer:	McNeil	
Nonproprietary Name:	Trenitoin	
Indications:	Mild to moderate acne	
Dosage:	Topical administration	
Supplied:	Saturated swabs Solution, 2 oz. bottles	
PROLIXIN DECANOATE	Long-acting Major Tranquilizer	Rx
Manufacturer:	Squibb	
Nonproprietary Name:	Fluphenazine Decanoate Injection	
Indications:	Management of manifestations of schizophrenia	
Contraindications:	Those usual with phenothiazines	
Adverse Reactions:	Refer to package insert	
Dosage:	Intramuscular or intravenous injection should be given in accordance with insrtuctions in package insert.	
Supplied:	Cartridge needle units and vials, 25 mg./cc.	

DUPLICATE SINGLE DRUGS

ECONOPRED Ophth. Susp.	Antiinflammatory and Antiallergic	Rx
ECONOPRED FORTE Ophth. Susp.		
Manufacturer:	Alcon	
Nonproprietary Name:	Prednisolone Acetate	
Indications:	Inflammatory and allergic conditions of the eye	
Contraindications:	Those applying to corticosteroids	
Dosage:	Two drops topically in the eye (s) q.i.d.	
Supplied:	0.125 and 1% susp. Plastic drop-tainer 5 cc.	

COMBINATION PRODUCTS

STIMULAX	Mild Laxative	o.t.c.
Manufacturer:	Geriatric Pharmaceutical	
Composition:	Casanthranol 30 mg. Dioctyl Sodium Sulfosuccinate 250 mg.	
Indications:	Chronic functional constipation in the elderly and obstetrics	
Dosage:	One to two capsules after supper or on retiring	
Supplied:	Capsules	

NEW DOSAGE FORMS

MICRONOR		
Manufacturer:	Ortho	
NOR-Q.D.		
Manufacturer:	Syntex	
Nonproprietary Name:	Norethindrone	Rx
Indications:	Contraception	
Contraindications, Warnings and Precautions:	See package insert	
Dosage:	One tablet each day, every day of the year on the first day of menstruation	
Supplied:	Tablets, 0.35 mg. ◄	

Editorials



Fetal Breathing Movements

Boddy and Mantell[1] have apparently answered the question, "Does the fetus breathe before birth?" Back in 1888, Ahlfeld described breathing movements, but his ideas were not accepted because there was no direct proof that the movements were of the fetal respiratory muscles. The Oxford investigators utilized modern and sophisticated equipment to give credence to Ahlfeld's theory.

If fetal breathing occurs, it is reasonable to assume that some amniotic fluid will enter the bronchial tree, even though the lungs have not expanded and are solid. Reports of this occurrence have appeared, but the latest studies showed that this is not always true. A radioopaque contrast medium was injected into the amniotic cavity of animals and man. Although the contrast medium was swallowed and reached the gastrointestinal tract, none appeared in the bronchial tree. Early in pregnancy, amniotic fluid is said to enter the lungs.

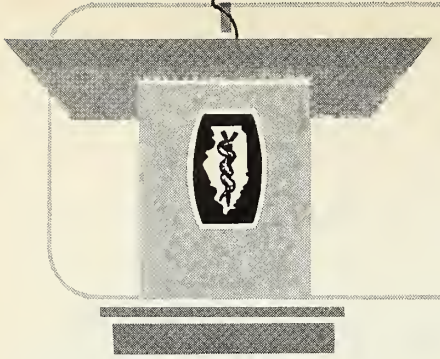
The authors also cite references that fetal lambs produced breathing chest movements even though the amniotic fluid was not inhaled. It was regarded as a sign of fetal health. To record fetal respiratory movements in urtero, Boddy and Mantell used a diagnostic ultrasonoscope on 100 women during the second half of pregnancy. In 34 women the sounds were transmitted through the maternal abdominal wall. The phenomenon was observed most often in multiparas toward term.

In five women, simultaneous readings were made on a polygraph recorder of the maternal wall movements, of the fetal thoracic movements, and the maternal pulse rate. The localized movements of the maternal abdomen coincided with fetal breathing (40-70 per minute) as compared with the maternal pulse rate (68-96). The next step was to determine what part of the fetus was responsible for the maternal abdominal movements due to fetal breathing. In some women the fetal thorax or upper abdomen was in close proximity to the maternal wall below the umbilicus. But in most instances, the breathing pulsation was transmitted through a fetal limb to a small area on the upper part of the abdomen. This differed in rate and character from the aortic pulsation.

Boddy and Mantell were of the opinion that progressive stretching and thinning of the uterine and maternal abdominal walls plus greater fetal size made fetal chest movements easier to detect with the ultrasonoscope.

T. R. Van Dellen, M.D.
Editor

[1]Boddy, K. and Mantell, C. D.: "Observations of Fetal Breathing Movements Transmitted Through Maternal Abdominal Wall." *The Lancet* Dec. 9, 1972, pgs. 1219-1220.



What goes on

a guide to continuing education

April 25–Martha Washington Hospital

Postgraduate Course—Chest Diseases

This course will be given by Richard Turbin, M.D., Chairman Radiology Department, assisted by Martin Berkowitz, M.D., Radiology.

There will be courses held on May 9, May 23, and June 6. For further information about the course described above or further courses contact: Dr. Fernando Lopez-Fernandez, Medical Director, Chairman, Continuing Medical Education Committee. Martha Washington Hospital, 4055 N. Western Ave., Chicago, IL 60618.

Martha Washington Hospital, Chicago.

April 26-28–Judicial Council, American Medical Association

Fourth National Congress on Medical Ethics

There will be a wide variety of views and ideas covered on the subject of medical ethics. Some of the topics will be: Comparative Ethics of the Medical Profession, Medical Ethics—Voluntary or Compulsory —Medical Ethics and Discipline-Medical Ethics and the Medical Student-Resident and Nurse.

Registration only: No Fee, Luncheon $6 per ticket. Contact: Walter H. Judd, M.D., Chairman Judicial Council, American Medical Association, 535 N. Dearborn, Chicago, IL 60610.

Washington Hilton Hotel, D.C.

May 9-12–Chicago Committee on Trauma–American College of Surgeons

Seventeenth Annual Postgraduate Course on Fractures and Other Trauma

Speakers will cover subjects such as pathophysiology of non-union, fractures of the femoral hip, posterior dislocation of the shoulder, and lesions confused with lumbar discs. Many other types of fractures and dislocation in children and adults will be covered.

Registration Fee: $140.00. There is a $15.00 reduction if received by Feb. 15.

Sheraton Chicago Hotel, Chicago.

April 29-30–American Medical Association

AMA Congress on Environmental Health

Speakers drawn from the fields of law, federal and state government, private foundations, architecture, the universities, private industry and industrial trade associations will discuss the problems of energy production as they relate to environment and human health during the two-day Congress. Registration Fee: $50.

Contact: Diane Dale, Department of Environmental, Public and Occupational Health, American Medical Association, 535 N. Dearborn, Chicago, IL 60610.

Ambassador West Hotel, Chicago.

April 30-May 4–Northwestern University Medical School

Review Conference for Senior Radiology Residents: Physics–Nuclear Medicine–Radiobiology

The purpose of this conference is to review the basic, applied, and clinical aspect of physics, nuclear medicine and radiobiology which are of concern, interest and use to radiologists. Emphasis will be on the refresher and review aspects of each area rather than on presentation of new material. The conference will include lectures, discussion, and demonstrations.

This conference is intented primarily for senior residents in all areas of radiology. It is ideal for residents planning to take the Boards. However, radiologists who wish an intensive review of radiological physics are also welcome. Contact: W. J. McGonnagle, Ph.D., Northwestern Memorial Hospital, Wesley Pavilion, Superior Street and Fairbanks Court, Chicago, IL 60611.

Fee: $75.00.

Northwestern University Medical School, Chicago

May 4-5–Rush Presbyterian St. Luke's Medical Center–American College of Chest Physicians

Postgraduate Course: Cardiovascular Emergencies

Course offers nine hours of credit for the American Medical Association Physician's Recognition Award, and will provide a comprehensive review of the recent advances in the diagnosis and treatment of a variety of life-threatening vascular emergencies, both venous and arterial. Major emphasis will be placed on pathophysiology and the principles of surgical treatment.

Contact: American College of Chest Physicians, 112 E. Chestnut St., Chicago, IL 60611.

Rush-Presbyterian-St. Luke's Medical Center, Chicago.

May 11-12–Chicago Section of the American Association of Clinical Chemists

Interdisciplinary Conference on Amniotic Fluid

The conference will be in cooperation with the Chicago Gynecological Society, the Chicago Pediatric Society and the Chicago Immunological Society.

Dr. DeWitt Stetten, Director, National Institute of General Medical Sciences, National Institute of Health, Bethesda, Maryland, will keynote the conference with a discussion on "Centers for Genetic Disease Study, Genetic Counceling and Amniocentesis."

There will be scientific exhibits demonstrating, in work shop fashion, the methodology for obtaining amniotic fluid and analyzing for the various components sought. In addition, there will be demonstration on the culturing of cells for observing chromosome abnormalities in genetic disorders.

Contact: Antonio Scommegna, M.D., Michael Reese Hospital, 29th Street and Ellis Avenue, Chicago, IL 60616.

Michael Reese Hospital, Chicago.

Doctor's News

ISMS Members Visit Capitol Hill and San Juan



ISMS members and spouses listen at congressional briefing during the annual Washington Roundup. This annual event, sponsored by the Governmental Affairs Council, allows the group to meet with various legislators. The attendees heard addresses on "Status of HMO's" by Stephan E. Lawton, Counsel, House Subcommittee on Public Health and Environment; "Status of PSROs and National Health Insurance Proposals," by William Fullerton, Staff Assistant House Ways and Means Committee; Senators Adlai E. Stevenson, III, and Charles H. Percy. Several ISMS members and their wives continued the trip to San Juan where they met with officers and members of the Puerto Rico Medical Association.



U.S. Congressman Bob Hanrahan (third from the left) views a **Congressional Record** with ISMS officers during the Washington Roundup. Looking on with Mr. Hanrahan are (left to right): Willard C. Scrivner, M.D., 1973 ISMS President, Frank J. Jirka, Jr., M.D., immediate Past President, and William M. Lees, Chairman of the Board of Trustees.

INTRAVENOUS SOLUTION RECALLED—The Illinois Department of Public Health is notifying hospitals and nursing homes to withhold using 5% Dextrose Lactate Ringers I.V. Solution manufactured by Cutter Laboratories.

The recall extends to all lots of the solution produced at Cutter's Chattanooga, Tenn., plant since Sept. 13, 1972. The code numbers of the lots being recalled are: TK1159, TK1426, TKs118, TK3248, TK3268, and TK-3497, and all subsequent code numbers higher than TK3497.

ISMS RECEIVES AMA MEMBERSHIP AWARD—The Illinois State Medical Society is one of 27 constituent medical societies to receive a Membership Achievement Award for increasing their AMA membership during 1972. Between October, 1972, and January, 1973, over 500 physicians were added to the roster.

AMERICAN BOARD OF RADIOLOGY SETS EXAMINATION DATES—Written examinations for the American Board of Radiology will be June 16, 1973, in 13 selected sites. Oral examinations will be June 4-8, 1973, at the Mariott Motor Hotel, Chicago. For information contact C. Allen Good, M.D., ABR Secretary, Kahler East, Rochester, Minn. 55901.

PHYSICIANS IN THE NEWS—**Jerome Silver, M.D.**, Chicago has been selected President of the Louis A. Weiss Memorial Hospital Medical Staff. **Henri S. Havdala, M.D.**, has been named as Acting Dean of the Chicago Medical School at the University of Health Sciences. Dr. Havdala assumes the position vacated by **LeRoy P. Levitt, M.D.**, who recently was appointed as Director of the Department of Mental Health for the State of Illinois.

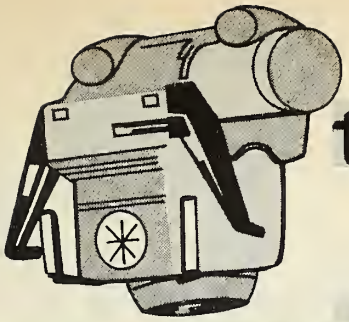
Stefano Stefani, M.D., will head the Radiotherapy Division at Mount Sinai Hospital and Medical Center, Chicago. **Samuel Spector, M.D.**, has been appointed Chairman of the Department of Pediatrics at the University of Chicago. **Alfred Heller, Ph.D., M.D.**, has been named as Acting Chairman of the Department of Pharmacology of the University of Chicago. **Vincent J. Collins, M.D.**, Director of the Division of Anesthesiology was elected again to serve as President of the Medical Staff at Cook County Hospital.

Morris Fishbein, M.D., Chicago, was one of four physicians to be honored by the American Geriatrics Society at their annual meeting. Dr. Fishbein received the Willard O. Thompson Award "for distinquished contributions to the field of geriatric medicine."

Roland Pritikin, M.D., of the Rockford School of Medicine of the University of Illinois, has been appointed "Lecturer in Opthalmology" to the Staff of the Fifth U.S. Army's Ft. Sheridan Health Clinic. **Robert D. Tetik, M.D.**, Research Resident, Department of Orthopaedic Surgery, Rush-Presbyterian-St. Lukes Medical Center, is receipient of the 1972 Dr. & Mrs. Elven J. Berkheiser Prize offered annually by the Institute of Medicine of Chicago. Dr. Tetik was recognized for his paper "Preliminary Evaluation of Polyethglese Graphite as a Material for Use in Total Hip Replacement."

Granville A. Bennett, M.D., former Dean of the University of Illinois College of Medicine will be presented an honorary degree from the U. of I. at the Medical Center during spring commencements. Doctors receiving Alumnus of the Year Awards from the Medical Alumni Association of the University of Illinois Medical Center include: **Martin A. Swerdlow, M.D.**, Kansas City, Mo.; **Vernon Wilson, M.D.**, Columbia, Mo. and **Woodruff L. Crawford, M.D.**, Rockford. Dr. Swerdlow will receive the service to education and research award; Dr. Wilson will receive the award for service to government and Dr. Crawford will receive the service to practice of medicine award.

Roy Patterson, M.D., will hold the newly established Ernest S. Bagley Chair for Asthma at Northwestern University Medicine School. Dr. Patterson is Professor and Associate Chairman of N.U.'s Department of Medicine and Chief of the Allergy and Immunology Section.



the view box

LEON LOVE, M.D./CHAIRMAN/DEPARTMENT OF RADIOLOGY
LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE



This patient was a 12-year-old boy who had been hit by a car. A palpable mass was noted in the lower abdomen and an IVP was ordered because of hematuria (Figure 1).

What's your diagnosis?

(Answers on page 386)

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Lawrence Knox, M.D.

Interview with Dr. Knox:

Special Report On The New ISMS Professional Liability Insurance Program

In January, 1973, the Board of Trustees approved the recommendation of the ISMS Insurance Committee for a new society-sponsored professional liability insurance program. The Hartford Insurance Group will underwrite the new plan which will be effective June 1, 1973, the date the current sponsored plan terminates.

Early in April all members received a descriptive brochure and application. Physicians who attended the Midwest Clinical Conference in March had the chance to visit with representatives of Johnson & Higgins, the insurance brokerage firm that will administer the program. To give you the background behind the Trustees' decision the Illinois Medical Journal *recently held an exclusive interview with Dr. Lawrence Knox, Chairman of the ISMS Insurance Committee.*

Dr. Knox, an internist with a sub-specialty in nuclear medicine, is a member of the American College of Physicians, the American Society of Internal Medicine and the American Society of Nuclear Medicine. A native of Baltimore, Md., he received his premedical education at Loyola University and his medical degree from the University of Maryland. In 1954 he joined the Weber Clinic in Olney, which is a partnership of 22 physicians with a staff of over 100 para-professional and administrative employees. Located in a prosperous farming community of 10,000 in southeastern Illinois (Richland County), the Clinic and the nearby Richland Memorial Hospital serve an extensive, multicounty area.

Dr. Knox is active with a wide range of interests. One of his interests has been insurance as it relates to medical economics, an interest which culminated in his appointment to the ISMS Insurance Committee in 1965 and to its chairmanship in 1972.

ISMS: Dr. Knox, we understand that Employers' Fire Insurance Company, which has underwritten the society malpractice plan since 1968, notified your committee in December, 1972, that they were going to terminate the plan on May 31, 1973. Did that give you enough time to find another insurance company?

Dr. Knox: We might have had a time problem if the company's notice had caught us by surprise, but we had some earlier indication that Employers' Fire was disenchanted with its entire block of malpractice insurance. For example, the company pulled out of its Florida program several months before.

Actually, some of us on the committee became disenchanted with Employers' long before that—not only because of the drastic rate increases—but because we weren't always kept as well-informed about the program as we should have been.

We had been in touch with Johnson & Higgins as far back as July, 1971, to hear about its program in southern California. And in May, 1972, we authorized that company to conduct a six month study of the malpractice situation in Illinois. Part of their study included a proposal for the new Hartford program, so we weren't unprepared.

ISMS: Did any other companies submit proposals?

Dr. Knox: Yes. In January the committee heard presentations from three brokers and insurance companies in addition to Johnson & Higgins and the Hartford Insurance Group. We listened to four groups of insurance men during an eight-hour day, we then deliberated among ourselves and conferred for several days before arriving at a decision.

ISMS: Why did you choose the J&H-Hartford plan?

Dr. Knox: To start with, the plan itself is a good one. But the most important reason is that the J&H-Hartford approach to professional liability insurance has been working successfully in south-

ern California since 1970. Members of our committee spoke with several of our medical colleagues in Los Angeles, and those physicians were unanimous in their unqualified endorsement of the Hartford and J&H.

With all due respect to insurance men, physicians tend to listen to other physicians. We're generally skeptical when we talk with people outside our profession who are trying to sell us something. The comments of the Los Angeles physicians really sold us. If a professional liability program can work in California, which has been a real problem area, it can certainly work in Illinois.

ISMS: Why will it work?

Dr. Knox: Because we doctors will control our own program through a peer review mechanism, and because J&H and Hartford will provide us with complete disclosure of all the financial operations of the plan every quarter. Everything from the rating structures, claims by type of incident and location and specialty, enrollment percentages, insurance company reserves, insurance company expenses, etc. will be readily available to us. In this way we can work with the broker and insurance company to attack any problems before they become unsolvable.

ISMS: How will peer review apply to this program?

Dr. Knox: In two ways—(1) in reviewing applicants to be insured (the underwriting process), and (2) in reviewing all claims. We are now establishing professional liability medical review committees, with the approval of the ISMS Trustees, at the state and district levels. Most of the physicians who will serve on these committees are already members of society peer review committees or of the Illinois or Chicago Foundations for Medical Care. So the peer review concept will not be new to them. They will also represent the major specialty groups. In addition, the committees will be able to appoint consultants when necessary on a case by case basis.

ISMS: Please explain the underwriting procedure.

Dr. Knox: The ISMS administrative staff will refer all applications from physicians who have indicated a history of a malpractice incident within the past five years to the appropriate medical review committee for review *before* the applications go to the insurance company. The insurance company will also refer applications back to the committee when the company has knowledge about the applicant that might affect his insurability.

A member of the committee will then conduct his investigation, using all these methods:

- Personal discussion with the applicant
- The applicant's office records
- Hospital records
- Pertinent information in the ISMS or county medical society files

The committee will then evaluate the doctor's standard of practice and recommend to the insurance company that the applicant be accepted at standard, accepted at substandard, or rejected.

ISMS: Is the committee's recommendation binding on the insurance company?

Dr. Knox: The insurance company must reserve the right to make the final decision; otherwise ISMS would be engaging unlawfully in the insurance business. But the medical review committee's recommendation will generally determine the Hartford's decision. Otherwise we'd be participating in an expensive and time consuming exercise.

What we have to guard against is our medical review procedure becoming a whitewashing vehicle. The vast majority of physicians in this state practice standard medicine for insurance purposes. This includes most physicians who have been involved in claim incidents. We have an obligation under a society-sponsored professional liability program to see that these members are insured, for which the insurance company recognizes that obligation.

But, within the ISMS community of over 11,000 members there are bound to be a few doctors who are practicing medicine that is either unacceptable or substandard for insurance purposes. We also have an obligation to all members to recommend to the Hartford that those physicians be rejected outright, or that they pay more for their insurance, or that any future claim settlements include a deductible of, say, $1,000 or $2,000. In this way, we will exercise our financial control of the program as a whole and help assure its success.

ISMS: Are physicians really qualified to set rates and deductibles?

Dr. Knox: We are certainly qualified to determine if a doctor is performing ethically and within the scope of his practice, and if a past incident should be chargeable or not chargeable—whether or not any insurance company actually paid a claim. Based on a pre-determined point-rating system, which the medical review committee will administer, the Hartford will decide how much protection it is willing to write (for example, it might limit the applicant to a $100,000/300,000 policy even though he applied for higher amounts), or how much additional

premium it will charge (for example 25% more than standard), or if it will impose a deductible. Those determinations are the insurance company's prerogatives.

One more point before leaving this subject to avoid you thinking I'm placing undue weight on substandard underwriting—if the insurance company does set a deductible for a particular insured, it will only affect any future claim settlement—the deductible will not apply to any defense costs the company incurs for the physician.

ISMS: We now understand how peer review will work on selecting applicants. How will it work on claims?

Dr. Knox: Peer review in claims settlement is probably an even more important role for the society in controlling our own program. Whenever an incident is reported to the insurance company, the company's claim department will refer it to the appropriate medical review committee. The committee will then conduct its own investigation of the claim and arrive at a medical evaluation. Based on its evaluation the committee will then recommend to the insurance company whether to defend or settle the claim.

As part of the ISMS contract with the Hartford, the state medical review committee will also serve as a review board at the request of either the insured physician or the insurance company in situations where the company wants to settle a claim and the insured refuses to give his written consent. The committee's decision will be binding on both parties.

ISMS: Does this mean that the insurance company, with the consent of the medical review committee, can pay a claim even though the physician does not give his personal consent?

Dr. Knox: Yes, in a situation where the insured's peers, acting on all of the information available to them, believe that it's in the insured's best interest to settle. Before this would happen, however, the insured would have a full private hearing with his colleagues and would understand why the committee recommends settlement.

It makes sense for us to perform this role. We will talk the doctor's language. We can tell him that even though we agree that he did not commit malpractice in the medical sense, the legal aspects of the case might go against him. We can also assure him in many instances that if he accepts settlement he will not prejudice his future insurability under the program—and the insurance company will back us up.

On the other hand, there will be times when we will recommend to the insurance company that it defend the claim all the way—and the insurance company will accept our recommendation.

To summarize the peer review roles in our new program, ISMS members will:

- Weed out from the insurance rolls the very few uninsurable risks among us;
- Make it possible to insure some physicians who would otherwise have difficulty attaining coverage at a fair premium;
- Encourage physicians to report incidents promptly and agree to settle claims without damaging their reputations or future insurability;
- Provide a sympathetic, professional climate for defending claims that should be defended and settling claims that should be settled.

ISMS: May doctors who are using experimental procedures be insured?

Dr. Knox: Yes, our insurance committee will meet with ISMS members who are performing experimental clinical and surgical procedures. If the committee confirms that the physician is acting within the scope of his practice for the public good and practicing an acceptable standard of medicine, we will tell this to the insurance company. Even though the experimental procedure might entail an increased exposure to professional liability incidents, ISMS would thus demonstrate that we're willing to back the physician by not threatening his insurability under the program.

ISMS: Doctor, everything you've described so far sounds exciting, and we can see why you're enthusiastic. But what guarantee do we have that the insurance company won't follow its predecessor's action and decide to pull out of the program, too?

Dr. Knox: We have a written commitment from the Hartford that it will guarantee to underwrite the program for three years provided we attain a reasonable enrollment progression. At the end of three years, if 5,400 physicians are insured under the program, the Hartford will guarantee to continue the program for two more years—a total of five years in all. We think this is quite a commitment.

ISMS: We understand that after four years under the old society program, the enrollment was about 4,000

members, and moreover that a substantial number of Illinois physicians are insured with other companies. Is it realistic to assume, therefore, that 5,400 physicians will enroll under the new program?

Dr. Knox: It certainly is. First of all the society is growing. Secondly, the new program has many features besides peer review that make it attractive to all members—and for most physicians it's competitive with other programs in the state.

You and I know that we can't appeal to the membership to enroll in the program merely to support the society. Doctors are highly individualistic and are trained to think for themselves. The appeal has to be that the product is a good one for each individual. We believe that after the doctors read the literature made available to them, far more than 5,400 physicians will enroll in the program, and long before the three year deadline.

ISMS: Are the rates guaranteed for three years?

Dr. Knox: At each of the first three anniversaries of the program the insurance company has the contractual right to increase the premium up to 15%. It does not, however, have to exercise this right. In fact, in southern California, there has been only one rate increase in 2½ years. Having experienced rate increases of over 100% in Illinois in recent years, this 15% lid on increases is a reasonable provision.

ISMS: What happens in the fifth year?

Dr. Knox: Starting with the third anniversary, or after four years, the insurance company will set the rates on the basis of our own experience in Illinois. By then, the Hartford, with the help of the computer program that J&H will operate, will know exactly how the claim history and participation applies to physicians by location and specialty here in Illinois. The company can then set its rates by our actual experience. It might increase some specialties in some locations, reduce rates for others and completely revise the current five specialty rate classification and two rate territory classification system.

ISMS will be a party to these rate negotiations, with J&H acting in our behalf, and because we'll be controlling our own experience to a great extent through peer review, we'll have a lot to do with deciding the ultimate rate levels.

ISMS: We understand one of the major features of the new program is that the insurance company credits us with a portion of the interest it earns on the reserves? What does this mean?

Dr. Knox: We're all familiar with the effect of compound interest. What it means is that a substantial part of the premium the insurance company collects goes to establish a fund to pay future losses. That's the nature of professional liability insurance—or of all liability insurance, for that matter. After the insurance company subtracts its pre-determined expenses and the actual claim dollars it pays from the premiums, the balance becomes a loss pay fund. The insurance company invests this money and earns interest on it.

Under our program, the Hartford will credit 4% of the loss pay fund to the program, compounded quarterly—a lot of money—which will increase the amount of money available to pay claims. By increasing this fund, the interest credit helps reduce the effect of inflation and possible future rate increases because there will be more money to pay claims. It is a significant feature and one that J&H and Hartford introduced to professional liability insurance.

ISMS: Does the plan also provide for returning some of the premiums to the insured doctors?

Dr. Knox: Yes, it does. Once the program goes on the experience rating formula, any money in the loss pay fund not needed to pay that year's claims is available for return to each doctor.

ISMS: What are some other features of the plan that the members should know about?

Dr. Knox: One of the key features is the availability of optional limits. Physicians have a choice of $100,000/300,000 or $1,000,000, or $2,000,000, or $5,000,000 of basic professional liability protection, without the need of buying a separate professional liability umbrella policy.

The rates at the $1,000,000 and higher levels are especially attractive. I think physicians in this state—especially those in the Class 4 and 5 so-called high risk specialties—should not consider lower limits. Certainly, limits below $100,000/300,000 are not indicated in today's climate.

Another feature is that premiums are payable quarterly at no addtional charge. Paying premiums quarterly is a convenient method, especially for the higher rate classifications, because a doctor will not have to make the relatively high cash outlay that an annual premium structure requires.

A third feature is that doctors who select limits of at least $1,000,000 can also buy op-

tional personal excess liability insurance for a low additional premium. This coverage offers protection over and above the limits of basic automobile, homeowners and boat liability insurance.

ISMS: A growing number of Illinois physicians practice in professional partnerships and corporations. How will this program work for such organizations?

Dr. Knox: All the partners or corporate owners must be insured individually under the Hartford. Provided each of them has at least $1,000,000 of insurance, the corporation or partnership may be covered under a separate policy for a minimal quarterly premium. This separate policy is strictly optional.

A physician practicing as a solo corporation who employs no other physicians may have the separate corporate policy without charge.

Finally, coverage for employed medical assistants and licensed lab technicians and X-ray therapists is available for a slight additional cost.

ISMS: We've covered a lot of ground today, Doctor. May we move now to a philosophical point? The program you have described is certainly well-conceived, and we share your confidence that it will go a long way toward solving the professional liability *insurance* problem for ISMS members. But what role do you see the society and possibly the insurance company and the broker playing in solving the greater problem physicians face today—that of the increasing incidence of malpractice allegations?

Dr. Knox: In other words you're asking how we can cure the disease instead of the symptoms? Let's start with the premise that the socio-economic factors that have led to the increased incidence exist in Illinois today. Our state is a demographer's dream. The population is shifting rapidly from urban and rural to suburban—and we know that suburban residents tend to sue more frequently in all personal injury claims. My colleagues and I practicing in this small town are no longer immune to the problems that physicians in Cook, Lake or Madison Counties have.

There is a physician shortage in the state, and there might be a correlation between a high incidence of malpractice claims and a shortage of physicians. Our physician population contains a large percentage of specialists and we know that busy specialists might not develop the necessary rapport with their patients to avoid frequently unwarranted malpractice allegations.

There are other factors, of course, and our insurance program can't do anything about them, nor can we expect it to. However, our society and the insurance company and the broker can work together effectively in several ways to reverse the trend. We can design educational material for physicians—for the private practitioners as well as the student and intern and resident—film strips, tape cassettes, seminars. The insurance men can keep our active medical-legal committee and staff informed of new legislative developments throughout the country. The insurance carrier can cooperate in any experimental compulsory arbitration or medical-legal screening programs we establish. And we can all educate the public on what it should reasonably expect from our profession.

One of the things that has impressed our committee about the J&H and Hartford representatives we've met is their eagerness to help us solve some of the problems that go beyond designing an insurance policy. We believe we have entered into a long range program with the best possible lineup and we strongly recommend that every ISMS member join with us.

ISMS: Thank you, Dr. Knox. ◄

(Ed. Note: Members wishing more information on the new program may write ISMS Insurance Committee, Suite 2010, 360 N. Michigan Ave., Chicago, 60601, or telephone (312) 782-1654.)

Happy vs. unhappy stress

Can 'Stress' affect your blood pressure? Does it cause ulcers? Will it shorten your life? Not if it's 'happy stress,' claims the Institute of Life Insurance, based on research performed by Dr. Clifton L. Reeder, a physician who heads a midwestern Life Insurance company.

"There are two kinds of stress," he explains. "One is the 'happy stress' of working hard or playing hard and truly enjoying it—in contrast with 'unhappy stress' when hard work or hard play become a chore. Unhappy stress creates all kinds of problems. Your mental creativity is stifled. Your bodily reactions are adverse. Your heart beats faster. Your blood pressure goes up. The normal arteriosclerotic process is accelerated. Aggravating (but rarely fatal) duodenal ulcers, spastic colon, headaches and backaches all take their toll. But not with happy stress, which is performance with satisfaction and a glow. Happy stress is a pleasure." *Licova News*

View Box

(Continued from page 379)

Diagnosis: This case is a good example of a patient with two conditions.

1. There is an obvious fracture of the right inferior pubic ramus with diastasis of the pubic symphysis. This has resulted in marked elevation of the bladder floor as a result of a perivesical hematoma.

2. The second condition demonstrated is a ureterocele on the left with resultant mild hydro ureter and minimal dilatation of the left kidney. This was an entirely incidental occurrence which might easily have otherwise escaped detection. A ureterocele is a dilatation of the lower end of the ureter which prolapses into the bladder, but is still covered by vesical mucosa and contains all the component layers of the ureteral wall. The condition is common in children, females more than males, and may be bilateral. Most ureteroceles are small, but occasionally huge ureteroceles are seen which obstruct the vesical orifice. A congenitally small ureteral orifice is conducive to the development of a ureterocele. Ureteroceles are more frequent in reduplication of ureters and in such cases usually are associated with the ureter draining the upper renal segment.

Hydronephrosis, infection and the formation of calculus are commonly present. The radiograph reveals a dilated distal segment of ureter within the bladder separated from the contrast material in the bladder by a 2- or 3-mm area of radiolucency representing the walls of the ureter and the mucosa of the bladder. In cystography a radiolucent defect within the bladder near the ureteral orifice in children suggests a ureterocele even without visualization of the ureter. The combination of the bulbous dilation of the protruding ureter and the surrounding radiolucent halo has been called the "cobra head appearance." ◄

Perforated Jejunum Due to Primary Hodgkin's Disease

(Continued from page 344)

2. Irvine, W. T., Johnstone, J. M. "Lymphosarcoma of the Small Intestine with Special Reference to Perforating Tumors," *Brit. J. Surg.* 42:611, 1955.
3. Lukes, R. J., Butler, J. J., Hicks, E. B.: "Natural History of Hodgkin's Disease as Related to its Pathological Picture," *Cancer,* 19:317, 1966.
4. Molander, D. W., Pack, G. T.: "Hodgkin's Disease" Springfield, Ill., C. C. Thomas, 1968.
5. Wood, D. A.: "Tumors of the Intestine," *Atlas of Tumor Pathology. AFIP,* 1967.

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SPECIALTY REVIEW IN ALLERGY & IMMUNOLOGY, June 4
SPECIALTY REVIEW IN DERMATOLOGY, April 30
SPECIALTY REVIEW IN FAMILY PRACTICE, August 6
ADVANCES IN SURGERY, One Week, May 7
SURGERY OF TRAUMA, Four Days, May 14
MANAGEMENT OF TUMORS OF HEAD & NECK, One Week, June 11
ADVANCED PERIPHERAL VASCULAR SURGERY, One Week, July 16
COMMON GENETIC DISEASES, One Week, May 7
FAMILY PRACTICE REVIEW, One Week, May 14
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EKG of the month

(Continued from page 348)

Answers: 1 = b, c 2 = b, d 3 = d

This electrocardiogram is suggestive of a patient with cor pulmonale secondary to chronic obstructive pulmonary disease. The pattern which is usually present is that of prominent P waves in leads 2, 3 and AVF at least 2.5 mm in height, right axis deviation or an indeterminate QRS axis with small QRS voltage in the frontal plane. In the precordial leads the characteristic pattern is a rs or QS pattern from V1 to V5. This is frequently misdiagnosed as an extensive anterior myocardial infarction. However, in a post mortem study of patients who presented with this electrocardiogram and chronic obstructive pulmonary disease anterior myocardial infarctions were rarely found.

Professional Employers Covered by Occupational Health and Safety Act

(Continued from page 315)

safety inspectors of the U.S. Department of Labor. The Secretary of Labor may require employers to file reports of information contained in the above records for statistical purposes.

Inspections of any employers' place of employment may be made by the U.S. Department of Labor, either on its own initiative or at the request of an employee or employee representative. Fines may be imposed for violation of provisions of the Act or noncompliance with established safety and health standards. Imprisonment can also be imposed if a willful violation results in the death of an employee.

The Occupational Safety and Health Administration has indicated the following order of priority for its enforcement activities: First—situations involving accidents leading to death or serious injuries; Second—requests for inspections submitted by employees; Third—industries involving hazards from asbestos, lead, silica, cotton dust and carbon monoxide; Fourth—random inspections of covered employers. The likelihood of early inspections of medical offices or clinics seems relatively low unless a serious occupational injury or illness occurs or unless an employee requests an inspection. Employees are protected by the Act from discharge or other harassment for requesting inspections or exercising other rights under the Act. Reinstatement of discharged employees with back pay and other appropriate relief may be enforced by court action.

The administration of the Act is assigned to the Occupational Safety and Health Administration, U.S. Department of Labor, Washington, D.C. 20212. Posters, report forms and information about the Act and the applicable established safety and health standards may be obtained from the Region 5 office, 848 Federal Office Building, Chicago. ◄

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Obituaries

*Anderson, Kenneth W., Chicago, died at the age of 46. He was described as a man of excellent professional ability with a wide range of community interests.

*Carlisle, William T., died January 24, at the age of 76. He was a staff member of St. Luke's and Little Company of Mary Hospitals and a professor at Northwestern University Medical School.

*Compton, Joseph, Belleville, died at the age of 57. He was a leader of medical organizations throughout St. Clair County and the state. Included in his leadership were positions as Chairman of the St. Clair Medical Society, Disaster and Civil Defense Committee; medical advisor for the Civil Defense St. Clair County Regent; and former chairman of the Medical Advisory Committee for the Illinois Public Aid Commission. Dr. Compton was on the staff of five area hospitals.

*Denker, Merle J., Chicago, died January 27, at the age of 65. He was a general practitioner.

*Dudek, John M., Chicago, died February 18. He was a staff member of Holy Cross Hospital.

**Kutza, Michael, Chicago, died at the age of 75 on February 2. He earned his medical degree from the Chicago Medical School and joined the staff of St. Mary's of Nazareth Hospital in 1924. At St. Mary's he was president of the staff in 1962 and vice president in 1961. Dr. Kutza was a physician for 52 years.

*McCabe, George T., Morris, died February 21, at the age of 48. He received his degree from the Chicago College of Osteopathy and Loyola Medical School. Dr. McCabe was a member of the medical staff at Saint Joseph Hospital.

*Pope, Charles E., Evanston, died February 4, at the age of 73. He was a staff member of St. Francis Hospital in Evanston for 44 years.

*Puestow, Charles B., Chicago, died at the age of 71, on February 10. He was an internationally known surgeon and educator. He was affiliated with the University of Illinois for nearly 40 years where he began as an associate in surgery in 1931. Dr. Puestow was also Chief of Surgery at Hines Veterans Hospital, a post he held since 1946. He had been Medical Director and Director of Medical Education at Henrotin Hospital. As founder of the Illinois Surgical Society, he served as its President. Also, he was President of the Metropolitan Chicago Chapter of the American College of Surgeons.

*Towle, Victor M., Chicago Heights, died at the age of 67 on February 14. He had retired last year after a 40 year medical practice.

*Walsh, Frank J., River Forest, died February 9, at the age of 69. He was Assistant Professor of the University of Illinois School of Medicine and was former Chief of Obstetrics and Gynecology at Gottlieb Memorial Hospital.

*Willems, J. Daniel, Chicago, died at the age of 80. He had been Medical Director of the Lumbermens Mutual Casualty Co. and had been in private practice before he retired in 1956. ◄

*Denotes member of ISMS
**Denotes member of 50-Year Club and ISMS



Physician Recruitment Program

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program. This is a free service to all physicians.

Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 360 North Michigan Ave., Chicago, 60601.

ALBION: General Practitioner. Population 1,800, trade area 13,000 with only 4 physiicans in area. Office facilities, financial assistance available. Rural setting, county seat town; expanding economy, hospitals nearby. City park, swimming pool, tennis courts, etc. Unit school district, Community College 15 minutes. Contact: Don Broster, Citizens National Bank, Albion, 62806, 618-445-2344. (4)

AVON: General Practitioner. Population 1,000, trade area 3,500 to 4,000. Rural practice. Twenty-four bed hospital in town. Office facilities available. Recreational facilities nearby. Excellent area in which to practice and raise a family. Contact: Fred L. Janes, Avon, 61415, 309-465-3883. (4)

BLOOMINGTON-NORMAL: Population 80,000. General Practitioner in 3 man partnership—25 year establishment. Complete office, Lab., & X-ray facilities. Salary first year and full partnership thereafter. Three hospitals available, but only one used. Housing available—rent or buy. 90 miles from Chicago Loop. Contact: Homer C. Lyman, M.D., 5 Citizens Square, Normal. 309-452-1151. (8)

BUNKER HILL: Population 2,000; friendly community. Opening for general practitioner. Five hospitals within a 30 mile area. No recreational facilities, but we need you. Surrounding country practice. Contact: Frances S. Stadelman, 110 W. Warren St., Bunker Hill, 62014, 618-585-4565. (5)

BUSHNELL: General Practitioner. Where a doctor can have a family life. Population 3,800. Literally minutes from stocked lakes, water sports. Good hunting. Your dream home costs less. State University close by. Our doctor did Europe all September. Visit there, come home here. Contact: Jack Gordon, Box 150, Bushnell, 61422. 309-772-3141. (4)

CARBONDALE: 25 man multi-specialty in southern Illinois needs Internists, Dermatologist, OB-GYN, Family Practitioners. Generous salary and fringe benefits, early partnership. New, modern building. Developing medical school. Contact: Wayne Given, P.O. Box 1030. Carbondale. 618-549-5311. (4)

CARLINVILLE: G.P., I.M., Ped., OB-GYN. Population 5,700. Mid-way between St. Louis and Springfield. Serves 30-mile trading area of 50,000 population. Newly built physicians building adjacent to hospital. Modern office space for doctors. Modern 68-bed hospital fully equipped and staffed. Opportunity for building large practice. We need doctors. Contact: James Rives, Carlinville Area Hospital, Carlinville, 217-854-3141. (7)

CARROLLTON: You can't match or beat the medical opportunities in Greene County, for a family Physician. Group practice being set-up in a new office building near hospital. For further information write or phone: Drs. Caselton or Wilson or Ray Shoemaker, Carrollton, 62016, 217-942-6946. (4)

CANTON: Urologist and Pediatrician needed by 12-man multi-specialty group. Aggressive city of 15,000 thirty minutes from Peoria. Excellent starting salary leading to full share in corporation. Tax savings and pension plan. Many recreational activities in area. Contact: S. C. Johnson, Coleman Clinic Limited, 175 S. Main St., Canton, 61520, 309-647-0201. (5)

CASEY: G.P. wanted to join Medical Center Staff; lab, X-ray, P.T., remote EKG, IPPB, 2 Observ. Rooms, 2 Emerg. Rooms, 24 hr. Emerg. Ser., call every 4th wkend, 1 wk. day, pleasant community, good schools, numerous churches, exceptional recreational facilities, golf course, country club, airport. Contact: Howard G. Johnson, Casey Medical Center, Box 427, Casey, 62420, 217-932-4061. (4)

CHADWICK: General Practitioner. Population 600. Office faciilties available. Former physician left practice of twelve years to retire to West Coast. Five minutes from country club and twenty minutes from Mississippi River. Contact: LeRoy Foltz, 329 Marion, Chadwick, 61014, 815-684-5128. (4)

CHAMPAIGN-URBANA: Opportunities for Neurologist, Nephrologist, Internists, and Orthopedist in prospering 30-man group. One-third of doctors under 35. Affluent Big-10 town of 90,000 with top schools and real cultural/recreational attributes. Full Associateship after 18 months on excellent guarantee. Write or call collect: Joseph A. Zalar, Jr., M.D., Christie Clinic, Champaign, 61820, 217-384-1240. (4)

CHICAGO: Field Clinic has opening for an Internist with a specialty either in allergies, rheumatology, or gastroenterology. Salary is open. The Field Clinic is one block from Ravenswood Hospital, which is a 400 bed medical center. Contact: Kenneth Hatfield, M.D., 4600 N. Ravenswood Ave., Chicago 60640. 312-275-7700. (8)

COAL CITY: General Practitioner. Growing community, with trade area of 15,000, offers to a physician a completely equipped office. Free for six months. Only one hour from Chicago, three hospitals nearby, and great recreational facilities for leisure. Contact: John Nicoletti, Coal City, 60416, 815-643-8608. (4)

DE KALB: 33,000 Population. University town. Good schools—all religious denominations. Complete office facilities—X-ray & Lab.; with 6 physicians—including OB-GYN, General Surgeon, Family Practitioners. Need Internist & Family Practitioner. Financial assistance available. Contact Gordon Graham, 901 N. First, De Kalb, 60115, 815-756-6611. (4)

EFFINGHAM: Service area 60,000—Central Illinois at intersection of I-57 and I-70. G.P.s, OB-GYN, Urology, Orthopedic Surgeon, Internal Medicine. Clinic or solo practice. Progressive community. Contact: Don Kabbes, 503 North Maple Street, Effingham, 62401, 217-342-2121. (4)

EVANSVILLE: General Practitioner. Population 1,000 with a large rural area. We are 15 minutes away from any one of three new hospitals. We stand ready to build to one or two doctors' needs. Also, we have financial assistance available. Contact: Jim Biethman, Box 144, Evansville, 62242, 618-853-2629. (4)

FAIRFIELD: General Practitioners Wanted. Are you bored and want a challenge? Do you want to practice where they don't ask about your diploma, or your specialty? Are you genuinely interested in people and their problems, rather than diseases and cases? If so, come on down to Fairfield and get your feet wet! Write or phone collect: Jerry Vaughan, Box H, Fairfield, Illinois 62837, 618-842-2167. (12)

FLORA: Population 6,000. G.P., Int., OB-GYN, Ortho. Surg., Anesth., Ophth., ENT. Group or solo practice. Nine physicians at present. One hundred miles east of St. Louis on Route 50. Financial assistance available. Excellent school system. Outstanding parks and recreational facilities. Visit at our expense. For an appointment contact: Alvin J. Uebinger, Administrator, Clay County Hospital, P.O. Box 280, Flora, 62839, 618-662-2131. (4)

FREEPORT—population 30,000. Internist & Pediatrician urgently needed to join a corporate 9 man multispecialty group. Established in 1948, new building in 1970. Salary first year. Fringe benefits include $50,000 life policy and retirement plan. For additional information—Freeport Medical Clinic, Ltd., Freeport, 61032, K. H. Shons, Business Manager, 815-233-6131. (9)

GALESBURG: Galesburg Clinic. Population 40,000. Twelve man multispecialty group seeking Ophthalmologist, Orthopedist, Internists, Urologist and Family Physician. New clinic building connected to new hospital. Home of Knox College. Excellent schools, recreational and transportation facilities. A fine opportunity. Contact: L. S. Doyle, Administrator, 320 North Kellogg St., Galesburg, 61401, 309-342-1161. (4)

GENESEO: Ped., OB-GYN, F.P., Orth. Surg., Int. Med. Population 7,000 serving area 30,000 on Interstate 80, 2½ hours from Chicago, 25 miles from Quad-Cities metropolitan areas, over 300,000. Safe, ideal, small city living, 110 bed ultra-modern hospital, excellent schools, recreational facilities. Clement G. McNamara, 210 W. Elk St., Geneseo. Call collect 309-944-6431. (4)

GIBSON CITY: Int., Ped., OB-GYN, F.P. Rural community with hospital facilities. Half-hour to Champaign-Urbana or Bloomington-Normal or two hours to Chicago Loop. Office facilities are available as well as financial assistance if necessary. Contact: Robert E. Jones, Gibson Community Hospital, Gibson City, 60936, 217-784-4251. (4)

HARVARD: Population 5,200, estimated trading area 20,000. Three physicians at present, previously five. Center of rapidly growing area and financially sound. Sixty five miles northwest of Chicago, thirty miles east of Rockford. Community committee, including present doctors. Contact: Mrs. Catherine K. Oost, 58 N. Ayer St., Harvard 60033. 815-943-5261. (9)

HERRIN: Int., G.P., ENT, Anthes. Population 10,000-trade area 40,000. Near S.I.U., 90 miles to St. Louis. New offices, modern hospital. Beautiful vacationland, all outdoor sports. Financial assistance and salary guaranteed. Call collect Larry Feil 618-942-4710, Herrin Hospital, Herrin, 62948. (9)

ILLINOIS DRUG ABUSE PROGRAM: Full or part-time work in general medicine, psychiatry, research, administration, or any combination of the above. Excellent opportunities for treating all types of chemical dependence, as well as carrying out research on medical and psychiatric aspects of the addiction problem. Also, full or part-time work in special units including alcoholism, severe medical and psychiatric problems, and a discreet operation serving pregnant addicts. Contact: Edward C. Senay, M.D., 5700 S. Lake Shore Drive, Chicago, 60637, 312-955-9800. (4)

LEROY: Population 2,500. Opening due to death of only physician. Large practice. Excellent clinical and office facilities. Finanial assistance available. For complete information, contact: Al Provasi, 307 N. Chestnut St., LeRoy, 61752, Phone: Res. 309-062-5101; Bus. 309-962-2721 or Craig Pillatsch, 101 W. Center Ct., LeRoy, 61752, Res. 309-962-7781; Bus. 309-962-7171. (5)

LIBERTYVILLE: Family Physician wanted for medical group of three Family Practitioners. Originated in 1952—Incorporated in 1964—Remodeled in 1972. Fringe benefits: hospitalization, pension, profit sharing, bonus and others. Complete office facilities. Please Contact: Mark H. Fields, Jr., M.D., 716 S. Milwaukee Avenue, Libertyville, 312-362-1390. (4)

LITCHFIELD: F.P., OB-GYN, Ped., Int. Population 7,300, Trade Area 50,000 in 15 mile Radius. New 134 bed hospital. Midway between Springfield and St. Louis, Mo. on I-55. Good schools. Good recreational facilities. Financial assistance can be arranged. Contact: John Short, 723 N. Van Burean, Litchfield, 62056, 217-324-3937. (4)

MACOMB: G.P., Int., Ped. Population 19,000. Home of Western Illinois University. 200 bed open staff hospital. Modern offices available for solo or clinic practice in all specialties. Guarantee plus fringes. No pollution, crime or traffic problems. Rural living with urban culture and recreation. Contact: D. H. Dexter, M.D., Macomb Clinic, Doctors Lane, Macomb, 61455, 309-833-4176. (4)

MARSHALL: General Practitioner. A new medical center now open located 17 miles from Terre Haute where hospital is available. Recreational services include fishing and camping. Another lake is under construction for boating and swimming. Excellent schools. Financial assistance available. Contact: Donald B. Smitley, Cork Medical Center, 410 N. 2nd St., Marshall, 62441, 217-826-2361. (4)

MAYWOOD-DIXON: Population 35,000 and 20,000 respectively. Expanding multispecialty groups, directed towards comprehensive medical care—excellent opportunities for Internist, General Surgeons, Pediatricians, Emergency Room Physicians—now and in the future. Contact: Gene M. Gaertner, M.D., 1908 St. Charles Rd., Maywood, 60153, 312-344-5300. (4)

METROPOLIS: Physicians wanted. F.P., OB-GYN. Complete office facilities. Financial assistance available. Modern, well equipped hospital serving tri-county

area in scenic southern Illinois. Contact: Charles Russell, Administrator, Massac Memorial Hospital, Metropolis, 62960, 618-524-2176. (4)

MOMENCE: General Practitioner. Population over 4,000. Opening new health center 14 mi. from Kankakee and 50 mi. from Chicago on Route 1. Office facilities available—some financial assistance available. Contact: Rachel Simpson, 210 N. Dixie, Momence, 815-472-2751; or George Duguay, N. Dixie Hwy., Momence, 815-472-4833. (4)

MONMOUTH: Services area population 30,000. Opening for General Practice and General Surgeon with training in Orthopedics and/or Vascular Surgery. Modern well-equipped hospital—141 beds. Near Highways I-74 & I-80. Daily rail to Chicago. Flight service available. Safe place to raise family. Near medical school, liberal arts college. Contact: Roger E. Gurholt, 1000 W. Harlem Ave., Monmouth, 61462, 309-734-3141 X 261. (4)

MONTICELLO, IOWA. Trade area 15,000. Need six or seven additional doctors. Presently served by four physicians, all involved in General or Family practice. Could afford some specialties in combination with General Practice. Financial assistance available. Contact: John Wild, c/o John McDonald Hospital, Monticello, Iowa, 319-465-3511. (4)

MT. CARMEL: General Practitioner. Population 8,100. Medical service center for 25,000 population. Complete medical facilities. Five doctors at present. Rapidly growing area. All recreational and cultural facilities nearby. Assistance available. Contact: Walter Curry, 200 Lambert Drive, Mt. Carmel, 62863, 618-262-4534. (4)

OLNEY: Weber Medical Clinic, 23 man multispecialty group. Population 100,000+, new building, patient load increased 20%. OB-GYN, Orth., Int., Ophth., Oto., Derm., Urol.; 5 weeks vacation, 1 week educational leave per year, pension plan, life insurance, disability. Lovely community, no ecology problems. Contact: David L. Potter, Adm., 1200 N. E. St., Olney, 62450, 618-395-2223. (4)

OTTAWA: Population 20,000. Opening in Internal Medicine at the Ottawa Medical Center, S.C. Eight-man specialty group. Seventy-five minutes from Chicago Loop. New hospital opening date in October, 1973. Contact: D. E. Morehead, M.D., 313 W. Madison St., Ottawa, 61350, 815-433-1010. (5)

PAW PAW "Rent Free" modern clinic available: Progressive, growing community, wishes to locate services of general practitioner. Modern medical, dental clinic provided. Maintenance of brick building by occupants only requirement. Excellent opportunity for profitable practice, plus ideal family living in friendly small town atmosphere. Contact: Mrs. Darlene McLaughlin, Paw Paw, 815-627-8441. (5)

PEORIA: Population 325,000. Emergency Room position for fulltime physician. Located midway between Chicago, St. Louis, and Iowa City. Excellent minimum salary and benefits. 824 bed community general teaching hospital, affiliated with University of Illinois Medical School. Illinois State Regional Trauma Center. Contact: Personnel Director, St. Francis Hospital, Peoria, 61603, 309-672-2304 (4)

PINCKNEYVILLE: Population 3,500. Opening in small Group-Partnership for Family Physician. Fully accredited hospital. Complete office facilities. No financial investment. Excellent compensation and working conditions. Sixty miles from St. Louis. Good recreational facilities. Contact: Clarence E. Cawvey, M.D., 206 No. Main St., Pickneyville, 62274, 618-357-2131. (4)

PONTIAC: Population 11,000. 100 miles south of Chicago on Route 66. 10 physicians. Several retiring. Wanted: Family Practitioners, General Surgeon (one on staff), Internal Medicine (none on staff). Paid Emergency Room coverage available. Financial and office space available. Contact: Dale Buddle, 610 East Walter St., Pontiac, 61764. Call collect: 815-844-5134. (4)

PRINCETON: Population 7,800; county population 38,000. Excellent living conditions; good family community—no problems. Modern 180-bed hospital. Unlimited income for Family Physiicans and Pediatricians. 2 hours—Chicago; 1 hour—Peoria & Quad Cities on I-80. Call collect: John Revell, 606 South Main St., Princeton, 61356, 815-872-1255 or 815-875-3292. (4)

PROPHETSTOWN: Small town boy?? If you are a physician interested in General Practice, and want a small town life for your family, then Prophetstown may be the place for you. We invite your inquiries. Contact: Calvin W. Schuneman, 343 Washington Street, Prophetstown, 61277, 815-537-2301. (4)

QUINCY: OB-GYN, Ped., Ortho., Fam. Prac., Derm., Ind. Med. to join 17-man established clinic. Large modern clinic, many benefits, two well-equipped hospitals. Excellent schools, cultural, recreational advantages. Good family city. Above average earnings. Write or call collect: Mr. Judson C. Green, Quincy Clinic, 1400 Main St., Quincy, 217-222-6550. (4)

RANSOM: General Practice Opening. Death compels sale of practice. Modern equipment and brick building—consists of doctor's, nurses and receptionist's offices, large reception room, laboratory and office-treatment rooms. 80 miles southwest of Chicago. St. Mary's Hospital staff in Streator, practice reaches a 50 mile radius. Contact: Mrs. D. Jones, Ransom, 60470, 815-586-4229. (4)

RIDGE FARM: Population 1015. Seventeen miles south of Danville. No physician at present. Complete office facilities. Financial assistance available if needed. Contact: Nolin Weathers, 207 E. North St., Ridge Farm 61870. 217-247-2265. (8)

ROANOKE: General Practitioner. Population 2,050. Opening for one or two physicians. Excellent location for clinic-type facility. Financial assistance available. Space available, or will build to suit. Twenty-five miles from Peoria and Bloomington. All recreational facilities nearby. Contact: Elton Ulrich, Savings Building, Roanoke, 61561, 309-923-2831. (4)

ROSICLARE: G.P., Ped. Hospital serves 2 counties-approximately 10,000 people. Three Physicians at present. Office facilities, financial assistance & housing available. Modern, well equipped hospital. Located on Ohio River and in recreational area. Contact: Loeta Allen, Hardin Co. General Hospital, Rosiclare, 62982. Call collect: 618-285-6634. (4)

SALEM: G.P., Ped. Growing community with large rural area to serve. Financial assistance available. Fine schools and other municipal services. New 60-bed hospital addition under construction. Eighty miles from St. Louis. Contact: Edris Bachman, 520 Markland, Salem, 62881, 618-548-1944. (4)

SANDWICH: Population 5,500. 92-bed hospital serving 30,000. Need for two or three General Practice Physicians plus Internist plus Obstetrician plus Pediatrician. Single or group practice opportunities. The good life is here including economics, and also an hour from the Loop, etc. Contact: Marvin Tice, 11 East Pleasant Avenue, Sandwich, 60548, 815-786-8484. (4)

SAVANNA: G.P., Int. 5,000 population on Mississippi River. 40 bed open staff hospital. Excellent recreational facilities, excellent schools, churches of all denominations. Option to practice alone or in partnership. Financial assistance available. Contact: Wm. Dayton, 202 Meadow View Knoll, Savanna, 61074, 815-273-2221. (4)

SENECA: Wanted Family Physician—population 2,500, 70 miles southwest of Chicago. No doctor in town. Beautiful office building and equipment. Offer free rent with option to buy. Guarantee monthly gross. General Surgery knowledge helpful but not necessary. Two new hospitals—12 miles away with country driving. Contact: Marion L. Osborne, 135 E. Lincoln St., Seneca, 61360, 815-357-6172. (4)

SHERIDAN: General Practitioner. One or two doctors for modern medical center. Financial assistance available including part-time staff physician for state institution. Excellent hospital facilities. Good opportunity for doctor who enjoys his family. Contact: John Yuhas, Sheridan, 815-496-2272 days or Alvin Sebby, Sheridan, 815-496-2620 evenings or weekends. (4)

SOUTHWESTERN TERRITORY: General Practitioner, towns of Brighton, Medora, Piasa, Shipman, combined area population 7,500. Office and facilities available; partnership and or financial assistance available. Five general hospitals in surrounding area, country living, excellent churches, schools, shopping areas. St. Louis and Springfield one hour away. Contact: Kenny Lahr, Piasa, 62079, 618-729-4142. (4)

STREATOR: Population 18,000. Multispecialty group, 7 physicians at present. New air-conditioned facility across from St. Mary's Hospital. Guaranteed minimum salary. Incorporated. Paid vacation and post-graduate study. Excellent insurance benefits. All specialties needed urgently. Contact: Dr. C. T. Hawkins, Streator Medical Clinic, S. C., 104 Sixth Street, Streator, 60364, 815-672-0511. (4)

STRONGHURST: Progressive small town serving large rural area. Close to large advanced medical facilities, recreational facilities nearby. No racial or environmental problems. Contact: Robert Dillon, Stronghurst, 61480, 309-924-6411. (4)

TAYLORVILLE: Population 12,000. Two-year old, seven physician multispecialty clinic seeking General Practitioners, Internists and OB-GYN. Salary first year. Full partnership thereafter. 25 miles to Springfield and SIU Medical School. 90 miles to St. Louis. Many recreational facilities nearby. Contact: Tom Brewer, 600 N. Main Street, Taylorville, 62568, 217-824-8191. (4)

WASHINGTON: Population 10,000 plus, need family physician; financial assistance available, office of doctor, recently retiring, with some equipment available. Ten minutes from Peoria. All recreational facilities available in or near Washington. 1 year free use of car provided, 6 mo. rent free residence available. Contact: Dean R. Essig, 139 Washington Square, Washington, 61571. (7)

WATSEKA: Population 5,800. Opening in established medical clinic, 4 Physicians at present. Complete office faciilties. Lab & X-Ray. Need GP and Internal Medicine. Contact: Francis Carter, 845 S. 4th Street, Watseka, 60970, 815-432-2461. (4)

WATSEKA: Population 5,800. General Practitioners needed. Clinic or single opportunity available. 16 physicians at present. Eighty-five miles from Chicago. New facilities, 114-bed hospital. Specialist available. Contact: Administrator or Chief of Staff, Iroquois Memorial Hospital, 200 Fairman Street, Watseka, 60970, 815-432-5201. (7)

WITT: Physicians needed in section of county to serve over 20,000 people. A modern building complete and ready for two doctors. Financial assistance available. Country living with access to big city attractions, St. Louis, Mo. Contact: Louis Schwartz, Witt, 62094, 217-594-2431. (9)

WOODSTOCK: Population 11,000, close to Chicago, growing community, complete office facilities with laboratory and X-ray, new 150 bed hospital well equipped. Need internist and pediatrician. Contact: J. Tambone, Northwest Clinic S. C., 102 E. South St., Woodstock, 60098. 815-338-2345. (8)

WOODSTOCK: Int., Ped. to join young 9-man multispecialty group in rapidly expanding area 60 miles NW of Chicago—Excellent Hospital—1st year minimum ($30,000)—Full member after one year—No buy-in's. Contact: Dr. Pensinger, Kishwaukee Valley Medical Group, S.C., 13707 W. Jackson St., Woodstock, 60098, 815-338-6600. (4)

WONDER LAKE: Associate Wanted. Residential oasis on privately owned 12-mile shoreline lake. Summer-winter sports. Good schools, many churches. 55 miles from Chicago, Milwaukee, Rockford. Two local hospitals. Complete facilities for Family Practice. Contact: S. L. Ruggero, M.D. ABFP, Box 137, Wonder Lake, 60097. 815-653-2131. (8)

Watch For Highlights
of the
ISMS Annual Meeting
in the
May Issue of the
Illinois Medical Journal

BLUE SHIELD REPORT FOR *Illinois Physicians*

HIGHLIGHTS OF 1972 ANNUAL REPORTS REVIEWED

Illinois Blue Cross and Blue Shield financial operations achieved new subscriber income levels, cost containment programs of the two corporations were expanded and further support given to new health care delivery systems in 1972, Chief Executive Officer Robert M. Redinger disclosed in the corporate annual reports.

In reviewing significant highlights of operations for the year, Mr. Redinger cited the following:

—Blue Cross provided more than $306 million in health care benefits for almost 3 million members last year. This was the sixth consecutive year of increased benefits. Blue Shield benefits to subscribers set an all-time high of over $73 million.

—The two corporations provided an additional $436 million in Medicare benefits as administrators of Part A (hospital) and Part B (medical-surgical) programs. This is an increase of almost $38.5 million over total benefits paid in 1971. Blue Cross administers the Part A program for the federal government throughout Illinois and Blue Shield Part B to residents of Cook County.

—Nearly 3.8 million claims were processed and paid by Blue Cross and Blue Shield operations including Medicare in 1972, compared with the previous year's record high of 3.7 million claims.

—Blue Cross received more than $333 million in membership dues from its non-Medicare programs in 1972, representing an increase of approximately $21 million over 1971. Blue Shield collected $83 million for its corresponding programs in 1972 compared with $69 million the previous year.

Putting Together New Relevant Programs

Blue Cross and Blue Shield took an innovative step in the health care delivery field during 1972 when the Plans became an active force in supporting the Health Maintenance Organization concept.

HMOs are systems that emphasize the importance of preventive medicine by providing periodic physicals, office visits, routine immunizations, prenatal care and other services directed toward early detection and treatment of illnesses. The services are provided to a defined population at the offices of physicians, usually organized as a group practice and charged at a prepaid rate per person.

Blue Cross and Blue Shield believe that HMOs permit an expansion in the scope of benefits and services available to subscribers, while having the potential to stablize health care cost.

Blue Cross and Blue Shield helped implement such a program in Illinois during 1971 in Carbondale, and now have initiated a comparable program called Coordinated Health Care (Co-Care) in the Chicago metropolitan area. Ravenswood Medical Group, associated with Ravenswood Hospital Medical Center on the north side of Chicago, became the first medical group to offer Co-Care in July 1972. Subsequently two more health centers were added to the program—Williams Clinic on the south side and the Field Clinic on the city's north side. Present plans call for the development of a network of such groups throughout the Chicago metropolitan area and eventually all of Illinois.

During 1972, Blue Cross intensified its efforts with Illinois hospitals and enrolled groups to make available expanded outpatient benefits. The benefits now are available in almost all Blue Cross programs and are designed to minimize the need for much more costly hospital bed care. Programs such as Pre-Admission Testing (P.A.T.); one-day surgery and Coordinated Home Care (hospital-type care continued at the patient's home) were promoted and established as on-going services in a number of Illinois hospitals during the year with encouraging results. At the same time, major emphasis was given to encouraging all Blue Cross groups to include outpatient X-ray and laboratory services in their employee benefit programs.

With the increasing need to provide as wide a scope of benefits as possible to our subscribers, changes were made in Blue Shield programs. New indemnity programs were offered with increased medical-surgical schedules. Maximum allowances are as high as $1,000, depending on the certificate.

Blue Cross and Blue Shield have been working for the past two years with Foundations for Medical Care sponsored by medical societies throughout Illinois. In their work with Foundations, the corporations have assisted in designing these programs and making them available to subscribers who wish to enroll in a Foundation-sponsored plan.

We have also provided support to the Sangamon County Medical Society, sponsor of the Foundation for Medical Care of Central Illinois, to assist in the development of an experimental program. This Foundation, working with Blue Cross and Blue Shield, is planning to enroll approximately 3,000 persons during 1973. Work is also underway with Foundations in other areas of the state.

PreDent Shows Gain in Subscribers

PreDent, a prepaid dental program underwritten by Blue Cross and Blue Shield's affiliate—Fort Dearborn Life—continued to gain acceptance in 1972. About 12,000 subscribers were added to the program. PreDent emphasizes preventive dental care and pays for diagnostic, preventive and restorative procedures.

ASK BLUE SHIELD . . . ABOUT MEDICARE

COVERAGE AND EXCLUSIONS OF DRUGS AND BIOLOGICALS

Payments for drugs and biologicals are made under Part B Medicare if the injections (1) cannot be self-administered (2) are not immunizations (3) are reasonable and necessary for the diagnosis or treatment of the illness or injury, and (4) meet all general requirements for coverage of items as "incident to" a physician's service. To fulfill the latter requirement the drug must be furnished by the physician and administered by him or his nurse under his personal supervision. The charge, if any for the drug must be included and itemized in the physician's bill.

The form of the drug or biological and its usual method of administration determine whether or not it can be self-administered. Pills or other oral medication, for example, are excluded from coverage since they can be self-administered. Injections for the "general good and welfare of the patient" are not considered a covered service. Insulin, which is usually self-administered, is excluded unless administered to a patient in an emergency situation, such as a diabetic coma.

Vaccinations or innoculations are regarded as immunizations and excluded unless directly related to the treatment of an injury or direct exposure to a disease or condition. Preventive immunization is not covered. Influenza injections are considered preventive treatment for the particular condition for which they are given. Vitamin B-12 and Endrate are two substances which cause some confusion in coverage. The Social Security Administration has determined the specific conditions and diagnoses for which they may be considered as covered injectibles in specific therapy: (1) Vitamin B-12 *for certain anemias*—pernicious anemia, megaloblastic anemias, macrocytic anemias, fish tapeworm anemia;

Certain gastrointestinal disorders—gastrectomy, malabsorption syndromes such as sprue and idiopathic steatorrhea, surgical and mechanical disorders such as resection of the small intestine, strictures, anastomoses and blind loop syndromes;

Certain neuropathies—posterolateral sclerosis, neuropathies associated with pernicious anemias, during the acute phase or acute exacerbation of the following: multiple sclerosis, trigeminal and glossopharyngeal neuralgia, neuropathies of malnutrition and alcoholism, tabes dorsalis, causalgia, postsympathectomy, parasthesias, diabetic neuropathies, herpes zoster and other inflammatory neuritides not due to mechanical or traumatic etiology.

(2) Endrate is covered when administered for emergency treatment of hypercalcemia and for the control of ventricular arrhythmias and heart block associated with digitalis toxicity. It may also be covered if indicated as necessary in the preparation of hypercalcemic patients for emergency surgical procedures and for temporary symptomatic treatment of patients with sclerodermas.

When billing for an injection, please include the following information: Date and place of service; name of the drug injected; the diagnosis; and the charge for the injection.

The Procedures of Medicare Claim Review and Fair Hearing

Physicians are often confronted with questions from patients when total charges on Medicare claims or a portion of those charges are disallowed by the carrier. If, after an explanation of medical benefits is made, the patients still want to know why all or a part of the claim was disallowed, the best course of action is to refer them to the Medicare carrier (Blue Shield in Cook County).

You or your patient may ask for this explanation in person, by phone or letter. The carrier will explain the denial or reduction of charges. The initial inquiry for an explanation of the determination does not constitute a review. A request for review is made by contacting the carrier in writing within six months of the date of Explanation of Medicare Benefits (EOMB).

If the six months time limit for filing a request for review has elapsed the carrier will consider whether there is "good cause" for the late filing. The carrier may also at its discretion or upon the request of the individual affected, extend the period for requesting the review.

The review is a completely new, independent and critical examination of the entire claim. Any additional information which will be of help in reviewing the claim should be included in the written request for a review of the disallowed charges. A review is a *prerequisite* to a fair hearing.

The fundamental purpose of the fair hearing is to give an individual or his representative who is dissatisfied with an adverse decision an opportunity to present in person the reason(s) for his grievance and to afford him an impartial hearing based on the substance of his claim.

Therefore, notice of an adverse review decision gives the individual the right to a fair hearing, notice of the time, place, manner of requesting it, time limit and the requirement that at least $100.00 must be in controversy. The amount in controversy, as determined in the 1972 Social Security Administration amendments, is the total amount in dispute, less the applicable deductible and the coinsurance.

SSA Change in Lab Certification

The laboratory listed below ceased operations January 1, 1973 and payments for Medicare services under the Health Insurance Program will no longer be made after that date:

Mount Prospect Clinical Laboratory
321 West Prospect
Chicago, Illinois 60056
Provider Number: 14-8111

IMJ
Illinois Medical Journal

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Abstracts of Board Actions Board of Trustees Meeting

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. It covers only major actions and is not intended as a detailed report. Full minutes of the meetings are available upon any member's request to the headquarters office of the ISMS.

March 24-28, 1973

Conrad Hilton Hotel, Chicago

Controversy Between Hospital Administration and Medical Staff

ISMS will develop an informational packet to assist medical staffs in their "negotiations" with hospital Boards of Trustees on proposed bylaw revisions. The packet—to be made available to all ISMS members upon completion—will include a set of model medical staff bylaws in line with ISMS legal counsel's interpretation that: "The practice of medicine is the physician's legal prerogative and responsibility. The quality of medical care in a hospital should be maintained and supervised through its medical staff. In helping to insure the quality of medical care, each hospital has the duty to cooperate with and assist its medical staff in developing procedures to accomplish this end."

Joint Membership Campaign

ISMS and the Chicago Medical Society agreed to sponsor jointly a membership drive for recruiting as many as possible of the estimated 3,000 physicians in Cook County who are not medical society members. Staff and expenses for the campaign will be shared by the sponsoring organizations.

IMPAC

Before stepping down as ISMS President, Dr. Frank J. Jirka, Jr., requested that every member of the Board of Trustees become a sustaining member of IMPAC. His proposal was approved unanimously.

Dr. Lees Announces Candidacy

Dr. William M. Lees, Chairman of the Board of Trustees, announced his candidacy for election to the AMA Council on Medical Education. Dr. Lees, who was elected by ISMS to occupy the additional delegate's seat recently given to Illinois by the AMA, received the support of the Board.

Constitution and Bylaws

A proposal to reorganize the district structure of ISMS was referred back to the Committee on Constitution and Bylaws for specific recommendations. The Board pointed out that any new district organization should include the delegates from each county in the district so that the delegates will be fully informed when they attend annual meetings of the ISMS House.

Officially opposed by the Board was direct membership of students in ISMS or the AMA because of the threat it presents to the unified membership concept. The Board will urge county medical societies to amend their bylaws to permit students to become members. Provision for student members in ISMS is contingent upon their being members of a component society. The committee was directed by the Board to study the question of SAMA membership as a prerequisite for ISMS membership. Such membership is one of the ways in which a student may join the AMA directly.

Past President's Medallion

The Board approved the awarding of miniature medallions to ISMS presidents on their leaving office.

Membership Renewals

By official action, the Board approved renewal of ISMS membership in the U.S. Chamber of Commerce and the Conference of Presidents and Other Officers of State Medical Associations, which sponsors the Forum for Medical Affairs at the AMA June meeting.

Meetings and Seminars

The Board accepted an invitation from the Jackson County Medical Society to hold its October, 1974, meeting in that county.

It also approved co-sponsoring an inter-professional seminar on Diseases Common to Animal and Man, August 16-17, in Urbana. The Board declined an invitation to co-sponsor a "JCAH Trustee-Administrator-Physician Institute" because a review of the proposed agenda for the meeting indicates strong emphasis on the American Hospital Association's Quality Assurance Program, to which ISMS has objections.

Credentialing Study Project

ISMS has withdrawn sponsorship on the Credentialing Study Program in which it has been involved with the Illinois Hospital Association and Illinois Nurses Association. According to the ISMS Executive Committee, the objectives of this program—credentialing of dependent health personnel—will be achieved under HR-1, which provides for equivalency-proficiency testing and career mobility for allied health personnel.

SAMA Request

The Board denied a Student American Medical Association request for a $1,000 contribution to underwrite the cost of coffee and rolls for participants at its May 4-6 annual meeting in Chicago. Since the SAMA program is a national meeting, the Board suggested that SAMA direct its request to the AMA.

IPhA Proposal

The Board refused to endorse an Illinois Pharmaceutical Association proposal to modify the current anti-substitution law as it applies to brand names of the same drugs.

Ambulatory Care Centers

ISMS will seek legislation classifying ambulatory care centers as "medical facilities" or "medical service institutions" to be licensed by the Department of Registration and Education. Such classification would make them immune from Certificate of Need laws and eligible for payment under Blue Shield and Part B of Medicare.

1974 Washington Roundup

Because of the success of the 1973 Washington Round-up, which included a medical seminar in Puerto Rico, the Board authorized the Executive Committee to explore the feasibility of expanding the 1974 program.

(Continued on page 468)



An Alternative to Hospitalization

Hospital care is today's most expensive health care item, accounting for nearly 40% of the nation's health dollar. Yet authorities estimate over 50% of all hospital admissions could be treated in an ambulatory care facility.

When critics attack the health care system, they point to spiraling costs. And hospital daily service charges have the fastest rising price tag The Social Security Administration reports that hospital charges for services provided under Medicare INCREASED 83% between 1966 and 1971. During the same period, however, physicians' charges DROPPED more than 5% for surgical services and 11% for outpatient care.

The Phoenix Surgicenter

Physicians in Phoenix, Ariz. have provided their patients with an alternative to unnecessary hospitalization for minor surgery—the surgical treatment center.

The success of the Phoenix Surgicenter is demonstrated by the fact that: (1) Procedure costs average about $128 less than hospital inpatient and surgical outpatient department charges: (2) Patient savings during the facility's first year totaled nearly $400,000; (3) 75% of its patients would have been hospitalized if the facility wasn't in operation; and (4) Surgicenter saved patients over 7,000 hospital days from February, 1970 to October, 1971.

Obviously surgical treatment centers represent competition for hospitals. When Surgicenter opened, four Phoenix hospitals felt the impact and promptly reduced outpatient charges. It is evident that the facility forced hospitals to re-evaluate their ambulatory care services. And it was the patients who benefited.

The Concept in Illinois

Now we are following Arizona's lead and attempting to eliminate unnecessary expense for our patients. ISMS is supporting legislation that, if passed, will authorize surgical treatment (ambulatory care) facilities in Illinois. We have argued for some time that many elective procedures can be done in these facilities just as safely and effectively as in a hospital.

But if the surgical treatment center concept is ever going to get off the ground in Illinois, it must not be shackled by the restrictive controls of agencies and institutions.

Hopefully, Comprehensive Health Planning will tolerate development of these surgical treatment centers. If they are classified as a type of hospital facility, CHP could prevent their construction by claiming they merely duplicate existing facilities.

Restrictive Insurance Coverage

In addition to overcoming the classification dilemma, ISMS also must resolve the problem of restrictive health insurance benefits. Some carriers encourage hospitalization by denying payment for services performed in free-standing outpatient medical and surgical facilities.

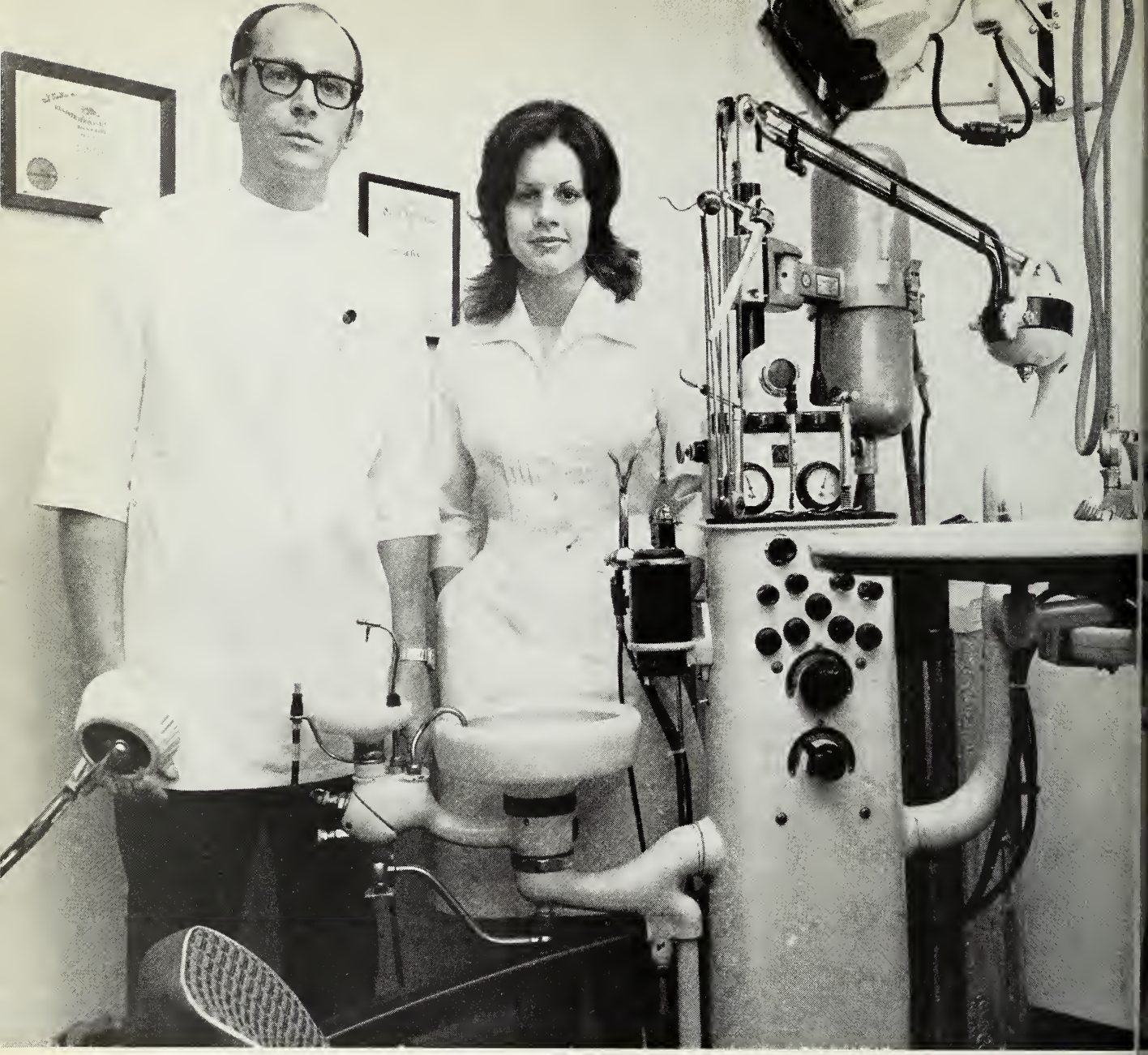
However, ISMS is working to amend "enabling" legislation to permit such payment by carriers in Illinois. And it is encouraging to note that Surgicenter, a free-standing facility, has been approved by nearly 100 Arizona carriers including the local Blue Shield plan.

We face a tough legislative battle in the coming months and need the full support of each ISMS member. Stay informed of developments regarding this legislation through "Action Report" and "On the Legislative Scene." Contact your state senators and representatives and let them know this bill has widespread physician backing.

With your support, we stand a good chance of winning the battle. Without it, we face insurmountable odds. ◄

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Administration of 2.4 million units (1.2 million in each buttock) of benzathine penicillin G usually • cures most cases of primary, secondary and latent syphilis with negative spinal fluid • helps break chain of infection • minimizes chance of immediate reinfection.

Indications: In treatment of infections due to penicillin G-sensitive microorganisms that are susceptible to the low and very prolonged serum levels common to this particular dosage form. Therapy should be guided by bacteriological studies (including sensitivity tests) and by clinical response.

The following infections will usually respond to adequate dosage of intramuscular benzathine penicillin G.—Venereal infections: Syphilis, yaws, bejel and pinta.

FOR DEEP INTRAMUSCULAR INJECTION ONLY.

Contraindications: Previous hypersensitivity reaction to any penicillin.

Warnings: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported. Anaphylaxis is more frequent following parenteral therapy but has occurred with oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens.

Severe hypersensitivity reactions with cephalosporins have been well documented in patients with history of penicillin hypersensitivity. Before penicillin therapy, carefully inquire into previous hypersensitivity to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and treat with usual agents, e.g., pressor amines, antihistamines and corticosteroids.

Precautions: Use cautiously in individuals with histories of significant allergies and/or asthma.

Carefully avoid intravenous or intraarterial use, or injection into or near major peripheral nerves or blood vessels, since such injection may produce neurovascular damage.

In streptococcal infections, therapy must be sufficient to eliminate the organism; otherwise the sequelae of streptococcal disease may occur. Take cultures following completion of treatment to determine whether streptococci have been eradicated.

Prolonged use of antibiotics may promote overgrowth of nonsusceptible organisms including fungi. Take appropriate measures should superinfection occur.

Adverse Reactions: Hypersensitivity reactions reported are skin eruptions (maculopapular to exfoliative dermatitis), urticaria and other serum sickness reactions, laryngeal edema and anaphylaxis. Fever and eosinophilia may frequently be only reaction observed. Hemolytic anemia, leucopenia, thrombocytopenia, neuropathy and nephropathy are infrequent and usually associated with high doses of parenteral penicillin.

As with other antisyphilitics, Jarisch-Herxheimer reaction has been reported.

Administration and Dosage: Venereal infections—

Syphilis—Primary, secondary and latent—2.4 million units (1 dose).

Late (tertiary and neurosyphilis)—2.4 million units at 7 day intervals for three doses.

Congenital—under 2 years of age, 50,000 units/Kg. body weight; ages 2-12 years, adjust dosage based on adult dosage schedule.

(Shake multiple-dose vial vigorously before withdrawing the desired dose.) Administer by **deep intramuscular injection** in the upper outer quadrant of the buttock. In infants and small children, the midlateral aspect of the thigh may be preferable. When doses are repeated, vary the injection site. Before injecting the dose, aspirate to be sure needle bevel is not in a blood vessel. If blood appears, remove the needle and inject in another site.

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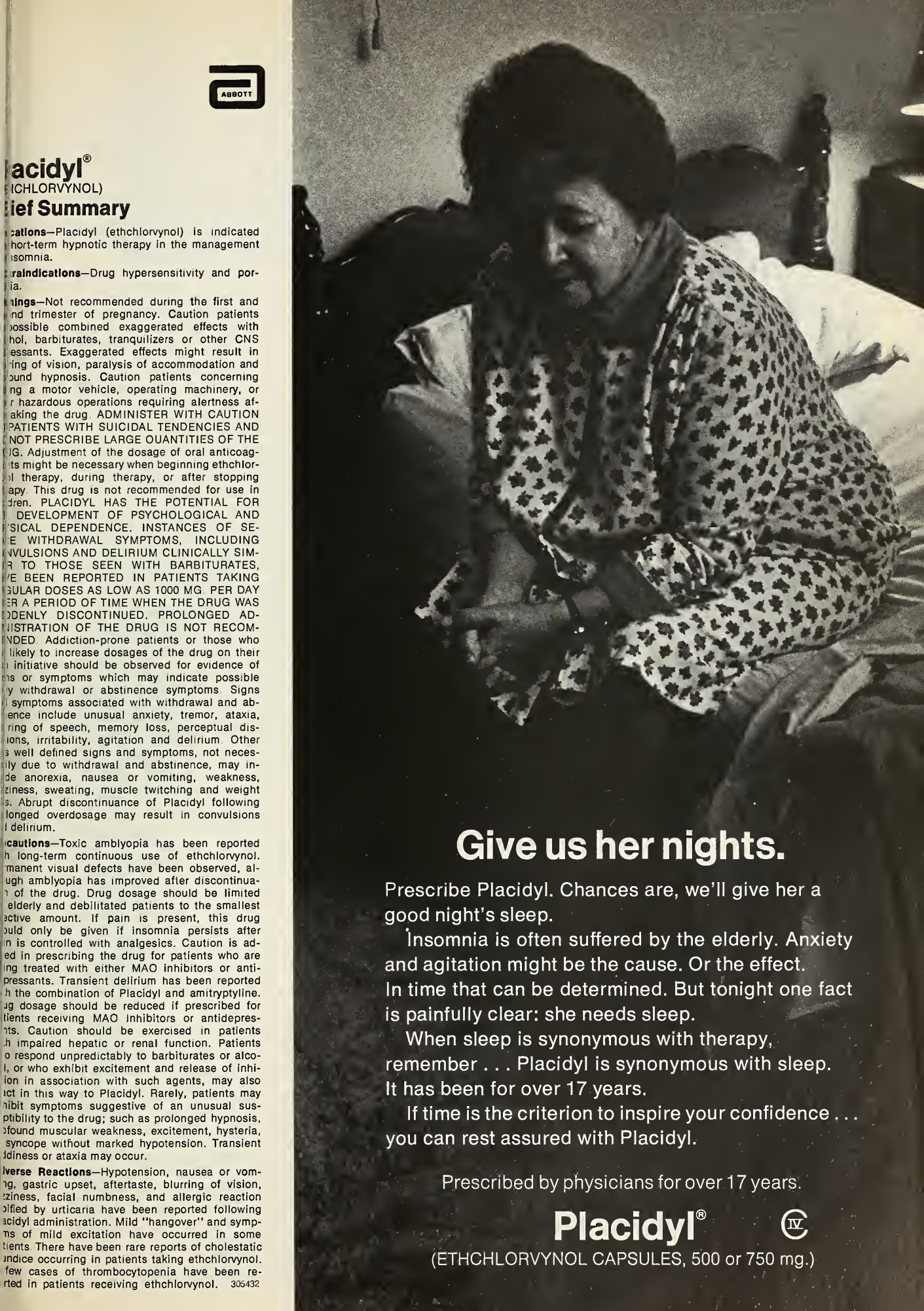
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nings—Not recommended during the first and nd trimester of pregnancy. Caution patients ossible combined exaggerated effects with hol, barbiturates, tranquilizers or other CNS essants. Exaggerated effects might result in ring of vision, paralysis of accommodation and ound hypnosis. Caution patients concerning ng a motor vehicle, operating machinery, or r hazardous operations requiring alertness aftaking the drug. ADMINISTER WITH CAUTION PATIENTS WITH SUICIDAL TENDENCIES AND NOT PRESCRIBE LARGE QUANTITIES OF THE IG. Adjustment of the dosage of oral anticoagts might be necessary when beginning ethchlorol therapy, during therapy, or after stopping apy. This drug is not recommended for use in dren. PLACIDYL HAS THE POTENTIAL FOR DEVELOPMENT OF PSYCHOLOGICAL AND SICAL DEPENDENCE. INSTANCES OF SEE WITHDRAWAL SYMPTOMS, INCLUDING NVULSIONS AND DELIRIUM CLINICALLY SIMR TO THOSE SEEN WITH BARBITURATES, VE BEEN REPORTED IN PATIENTS TAKING GULAR DOSES AS LOW AS 1000 MG. PER DAY ER A PERIOD OF TIME WHEN THE DRUG WAS DDENLY DISCONTINUED. PROLONGED ADISTRATION OF THE DRUG IS NOT RECOMNDED. Addiction-prone patients or those who likely to increase dosages of the drug on their initiative should be observed for evidence of ns or symptoms which may indicate possible y withdrawal or abstinence symptoms. Signs symptoms associated with withdrawal and abence include unusual anxiety, tremor, ataxia, ring of speech, memory loss, perceptual disions, irritability, agitation and delirium. Other s well defined signs and symptoms, not necesily due to withdrawal and abstinence, may inde anorexia, nausea or vomiting, weakness, ziness, sweating, muscle twitching and weight s. Abrupt discontinuance of Placidyl following longed overdosage may result in convulsions delirium.

cautions—Toxic amblyopia has been reported h long-term continuous use of ethchlorvynol. manent visual defects have been observed, alugh amblyopia has improved after discontinuan of the drug. Drug dosage should be limited elderly and debilitated patients to the smallest ective amount. If pain is present, this drug ould only be given if insomnia persists after in is controlled with analgesics. Caution is aded in prescribing the drug for patients who are ing treated with either MAO inhibitors or antipressants. Transient delirium has been reported h the combination of Placidyl and amitryptyline. ug dosage should be reduced if prescribed for tients receiving MAO inhibitors or antidepresnts. Caution should be exercised in patients h impaired hepatic or renal function. Patients o respond unpredictably to barbiturates or alcol, or who exhibit excitement and release of inhiion in association with such agents, may also act in this way to Placidyl. Rarely, patients may nibit symptoms suggestive of an unusual susptibility to the drug; such as prolonged hypnosis, found muscular weakness, excitement, hysteria, syncope without marked hypotension. Transient idiness or ataxia may occur.

Adverse Reactions—Hypotension, nausea or vomng, gastric upset, aftertaste, blurring of vision, ziness, facial numbness, and allergic reaction ified by urticaria have been reported following acidyl administration. Mild "hangover" and symns of mild excitation have occurred in some tients. There have been rare reports of cholestatic ndice occurring in patients taking ethchlorvynol. few cases of thrombocytopenia have been reported in patients receiving ethchlorvynol. 305432

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Twenty-Six Clinics For Crippled Children Listed for June

Twenty-six clinics for Illinois' physically handicapped children have been scheduled for June by the University of Illinois, Division of Services for Crippled Children. The Division will conduct 19 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social, and nursing services. There will be six special clinics for children with cardiac conditions, and one for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

June 5 Belleville—St. Elizabeth's Hospital
June 5 Carmi—Carmi Township Hospital
June 6 Hinsdale—Hinsdale Sanitarium
June 7 Sterling—Sterling Community Hospital
June 7 Lake County Cardiac—Victory Memorial Hospital
June 7 Flora—Clay County Hospital
June 7 Springfield—St. John's Hospital
June 8 Chicago Heights Cardiac—St. James Hospital
June 11 Peoria Cardiac—St. Francis Children's Hospital
June 12 Peoria—St. Francis Children's Hospital
June 12 E. St. Louis—Christian Welfare Hospital
June 13 Champaign-Urbana—McKinley Hospital
June 13 Springfield — Pediatric-Neurological — Diocesan Center
June 14 Kankakee—St. Mary's Hospital
June 14 Rockford—St. Anthony Hospital
June 19 Rock Island—Moline Public Hospital
June 20 Chicago Heights—St. James Hospital
June 21 Elmhurst Cardiac—Memorial Hospital of DuPage County
June 21 Bloomington—Mennonite Hospital
June 22 Evanston—St. Francis Hospital
June 22 Chicago Heights Cardiac—St. James Hospital
June 25 Peoria Cardiac—St. Francis Children's Hospital
June 26 Peoria—St. Francis Children's Hospital
June 26 Alton—Alton Memorial Hospital
June 26 Danville—Lake View Hospital
June 27 Aurora—St. Joseph Mercy Hospital

PROLOID® (thyroglobulin)
Caution: Federal law prohibits dispensing without prescription.

Description. Proloid (thyroglobulin) is obtained from a purified extract of frozen hog thyroid. It contains the known calorigenically active components, Sodium Levothyroxine (T_4) and Sodium Liothyronine (T_3). Proloid (thyroglobulin) conforms to the primary USP specifications for desiccated thyroid—for iodine based on chemical assay—and is also biologically assayed and standardized in animals.

Chromatographic analysis to standardize the Sodium Levothyroxine and Sodium Liothyronine content of Proloid (thyroglobulin) is routinely employed.

The ratio of T_4 and T_3 in Proloid (thyroglobulin is approximately 2.5 to 1.

Proloid (thyroglobulin) is stable when stored at usual room temperature.

Indications. Proloid (thyroglobulin) is thyroid replacement therapy for conditions of inadequate endogenous thyroid production: e.g., cretinism and myxedema. Replacement therapy will be effective only in manifestations of hypothyroidism.

In simple (nontoxic) goiter, Proloid (thyroglobulin) may be tried therapeutically, in nonemergency situations, in an attempt to reduce the size of such goiters.

Contraindication. Thyroid preparations are contraindicated in the presence of uncorrected adrenal insufficiency.

Warnings. Thyroglobulin should not be used in the presence of cardiovascular disease unless thyroid-replacement therapy is clearly indicated. If the latter exists, low doses should be instituted beginning at 0.5 to 1.0 grain (32 to 64 mg) and increased by the same amount in increments at two-week intervals. This demands careful clinical judgment.

Morphologic hypogonadism and nephroses should be ruled out before the drug is administered. If hypopituitarism is present, the adrenal deficiency must be corrected prior to starting the drug.

Myxedematous patients are very sensitive to thyroid and dosage should be started at a very low level and increased gradually.

Precaution. As with all thyroid preparations this drug will alter results of thyroid function tests.

Adverse Reactions. Overdosage or too rapid increase in dosage may result in signs and symptoms of hyperthyroidism, such as menstrual irregularities, nervousness, cardiac arrhythmias, and angina pectoris.

Dosage and Administration. Optimal dosage is usually determined by the patient's clinical response. Confirmatory tests include BMR, T_3 ^{131}I resin sponge uptake, T_3 ^{131}I red cell uptake, Thyro Binding Index (TBI), and Achilles Tendon Reflex Test. Clinical experience has shown that a normal PBI (3.5-8 mcg/100 ml) will be obtained in patients made clinically euthyroid when the content of T_4 and T_3 is adequate. Dosage should be started in small amounts and increased gradually with increments at intervals of one to two weeks. Usual maintenance dose is 0.5 to 3.0 grains (32 to 190 mg) daily.

Overdosage Symptoms. Headache, instability, nervousness, sweating, tachycardia, with unusual bowel motility. Angina pectoris or congestive heart failure may be induced or aggravated. Shock may develop. Massive overdosage may result in symptoms resembling thyroid storm. Chronic excessive dosage will produce the signs and symptoms of hyperthyroidism.

(Treatment: In shock, supportive measures should be utilized. Treatment of unrecognized adrenal insufficiency should be considered.)

How Supplied. ¼ grain; ½ grain; scored 1 grain; 1½ grain; scored 2 grain; 3 grain; and scored 5 grain tablets, in bottles of 100 and 1000.

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Man and His Environment*

By Paul Q. Peterson, M.D., Dean
School of Public Health, University of Illinois/Chicago

Our environment and the implications for first protecting and second improving its quality are staggering. The environment is the sum total of all external conditions that affect the life and behavior of man; and is, therefore, all of the physical, chemical, biological, sociological, and psychological factors within which man lives. Thus, it is difficult to think of any field of study or any endeavor that does not relate to the environment.

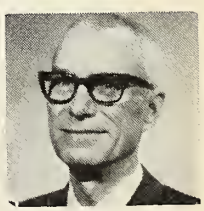
I ponder on the years during which public health problems in general and environmental health problems in particular have been regulated to the periphery of social and political concerns. We were always led to believe that medical and bioscience research, medical technology, clinical treatment, and institutional improvements would take care of all our health problems. We were usually advised that we were a bunch of lonely shepherd boys, crying "wolf" mainly to relieve our own boredom.

What we were seeing, but others refused to see or admit to seeing, was that man, since the beginning of time, has been struggling to improve his health and comfort through a heedless exploitation of nature. Man did not consider his resource supply to be limited and largely was guided by the philosophy that it was impossible to have progress without pollution and degradation of the environment; or stated differently, environmental quality is purchased at the expense of industrialization and economic growth. Now we find that a large number of people have discovered that we were really seeing wolves. Our problem is that now *we* are confused, because where we have been accustomed to being ignored, we now find significant numbers of people shouting with us. Then the very next minute they are shouting at us, and the only thing we can be sure about is that they are outshouting us all the time.

This is a disconcerting situation, to say the least, but remember all those lonely years when we pleaded for an aroused public, a public that might become involved? It seems to me that we may be on the verge of that time, at least insofar as environmental quality is concerned. I say the "verge of achieving public involvement" because that must be *responsible* involvement and "shouting" does not represent responsible involvement.

Compare such an involved and responsible public with those members of our society who decry the extent of air pollution and yet would not think of driving a car without the largest engine and highest compression ratio they can afford; and, who insist upon buying the highest octane leaded gas available. Or compare the "20th Century Don Quixotes" who jousted with the problems of the environment on "Earth Day" in Washington, D.C. last spring. When they departed they left behind a park so littered with trash it cost the government approximately 50¢ for each person who attended to clean up the Mall between the Washington and Lincoln monuments. Or those at a major eastern university where ground-crews spent two days cleaning up the campus after the "Earth Day" meetings.

Indeed, we must capitalize on the aroused public of today. We must capture their interest and understanding. We must help the public to recognize that we cannot deal with the unwelcome by-products of a complex, industrialized society if each member of that society acts as if he exists outside of the total structure of that society. What is needed is for the teeth of every member of society to "go on edge"



PAUL Q. PETERSON, M.D., M.P.H., was appointed Deon of the University of Illinois School of Public Health in Janvory, 1971. Dr. Peterson received his medical degree from the University af Illinais and his M.P.H. from the University af Michigan. He is o diplomate of the American Board of Preventive Medicine, a fellow of the American Public Health Association, and a member of the American Association for the Advancement of Science.

*Presented as the Fifth Roland C. Cross Memorial Lecture at the Illinois Public Health Association Meeting, April, 1971, Peoria.

when the quality of our environment is violated by the 'litterbug' or by industry.

Let us make it quite clear to all our people that the pollution, the crowding, the noise, the impersonality of modern life, the estrangement from the natural world, is not the utopia that the technological age seemed to promise. Man has assumed that progress would bring him freedom and a wholesome, enjoyable life. Instead, we must recognize that we find ourselves borne along by forces not of our own choosing, but which, to a significant degree we ourselves set in motion and are now incapable of controlling. It would be my hope that we might bring the American people to the conviction that they need to take a fresh look at the environment that *they* have created. They must turn to the realization that the technological genius that has provided abundance, ought to be able to do all these things without despoiling the environment on which human life depends.

Definition of Human Ecology

In this case it is my opinion that we have available to us the very real possibility of truly capturing the understanding and, therefore, the social commitment to rational and reasonable public health solutions of many of these major issues. It is my belief that the sudden surfacing of the term "human ecology" on the rushing stream of contemporary events, marks the beginning of a new awakening to the realities of man's relationship to nature. I am aware of the fact that the word ecology is rapidly approaching the dangerous precipice over which respectable and useful terms tumble when they become "cliche" words, used by persons who neither know nor apparently care what they mean. The word, ecology, is also threatened because many scholars who use it define it differently. My personal preference is the definition given the term by Doctor René Dubos, one of the great health philosophers of all times, "human ecology is the knowledge of the relationships between man and the innumerable factors of his environment."

In a world of multiple environmental impacts, where bacteria, carbon monoxide, tranquilizers, detergents, and pesticide residues may meet traces of antibiotics in the family soup pot, we can no longer allow ourselves the margin of error, with regard to environmental health and public safety which might have seemed permissible a few years ago.

The apparent tolerance of man toward conditions different from those from which he has evolved has given rise to the belief that he can modify his way of life and his environment without risk. This is simply not true. Modern man can only adapt himself insofar as his genetic mechanisms of adaptation are potentially present. Because we have begun to appreciate this fact, it should be clear that it is impossible to depend upon the natural assimilative capacity of nature and the natural adaptation of man in handling the problems of pollution of the environment. The cost in human values is too great, and more importantly, it is actually life-threatening. Therefore, government, industry, business, science, and each individual member of society must understand and be willing to do something about the impact we are creating on the environment within which we live.

The questions then appear to be, what are we now doing, and what will we do in the future to handle our environmental health problems? As I have suggested, the public health profession has been among the leaders in bringing environmental issues to public attention and supporting efforts to secure financing for environmental protection and research programs. The first programs in water pollution, water hygiene, air pollution, solid waste management, radiological health, and community sanitation were largely conceived and implemented within the official health agencies of local, state, and federal governments. These programs grew fitfully but never with strong support, until about ten years ago when the pollution of the environment began to arouse public and political concern, and suddenly the public health profession found itself being taken to task for program shortcomings.

This interest in the environment and the public reaction to it came at a time when public administrators were gripped by a new philosophy of management. That philosophy may best be described as a procedure whereby the correction of all faults was to be achieved through reorganization of programs. Some called it "removing organizational dry rot," others described it as organizational "self-renewal" and some less generous persons called it "politicization." Let me give an abbreviated account of what happened to the environmental health programs in the Federal Government as a case history. The water pollution program was moved out of the Public Health Service to the Department of the Interior. This called for a reorganization of the Public Health Service to accommodate to the loss of a major program element. Within less than two years, the organization of the Public Health

Service was again changed to give the remaining environmental programs greater visibility. Less than two years later all environmental programs with the exception of medical radiation, occupational health, and some elements of community sanitation, have been placed in an independent agency (Environmental Protection Administration).

Impact of Organizational Changes

The tragic results of these past seven years of organizational changes have been a constant decline in the ability of the programs to perform their assigned tasks. Staff has been so busy in trying to understand and function within the constantly changing administrative structure that performance and morale have deteriorated, with significant numbers of resignations particularly at the senior staff level. An even more disturbing consequence of this series of events has been the number of states that have followed the pattern of organizational arrangements and adjustments that have characterized the federal health agency. I have no specific information on the impact these changes are having at the state level. However, I can assure you that the states will need greater administrative and program skill than has been found in the Federal Government if program effectiveness and efficiency are to be maintained.

Recovery of a program from organizational abuse will occur in time. However, what has occurred and may cause lasting damage is the separation of programs related to man and his health and his environment. This creates a most serious further fragmentation of health programs. It is also such a serious violation of the principle of bringing essential elements of programs together to achieve social goals that one might question our ability to achieve success when we have moved to establish separate environmental *and* health programs. Man must be the central concern in any environmental quality program.

We are dealing in an equation that is dominated by man and nature, each of which responds within ranges which do not permit precise end-points. When dealing with disease caused by infectious agents, we know we deal with some mild self-limiting conditions such as the common cold; and we also are dealing with chronic debilitating diseases such as tuberculosis. We are aware that the degree of illness in either case depends upon the quantity of the infecting agent and its virulence, as modified by social factors and the individual's resistance to infection.

The same type of problem exists for man and his environment according to the definition of human ecology. There are the problems of solid waste that are principally concerned with the aesthetic quality of man's life, until the waste piles up and becomes a breeding site for insects and rodents and a dangerous reservoir of disease. On the other extreme is the exposure to ionizing and non-ionizing radiation. If man is taken out of the equation, there is no reason for concern regarding the levels of intensity or the sources of the energy, be they of natural origin, medical origin, industrial origin, or home appliance origin. The same logic produces the range of need for man to be the central concern whether we are considering air pollution, or water pollution, or any other environmental problem.

On the other side of that coin, if we try to consider man, his health, his well-being apart from his environment, we cannot treat his illness properly; we cannot adequately protect his health; and, most certainly, we cannot care for his well-being because so many of his human values have been taken away from health planning and health programs.

In more blunt terms, people with no knowledge of public health and unappreciative of the consequences of their action, have set in motion a series of management and political actions designed to separate environment and health. The result of that action to date has been to interfere seriously with program effectiveness and progress. The ultimate consequence will be to make our ability to achieve goals in environmental health much more difficult, more expensive, and less efficient.

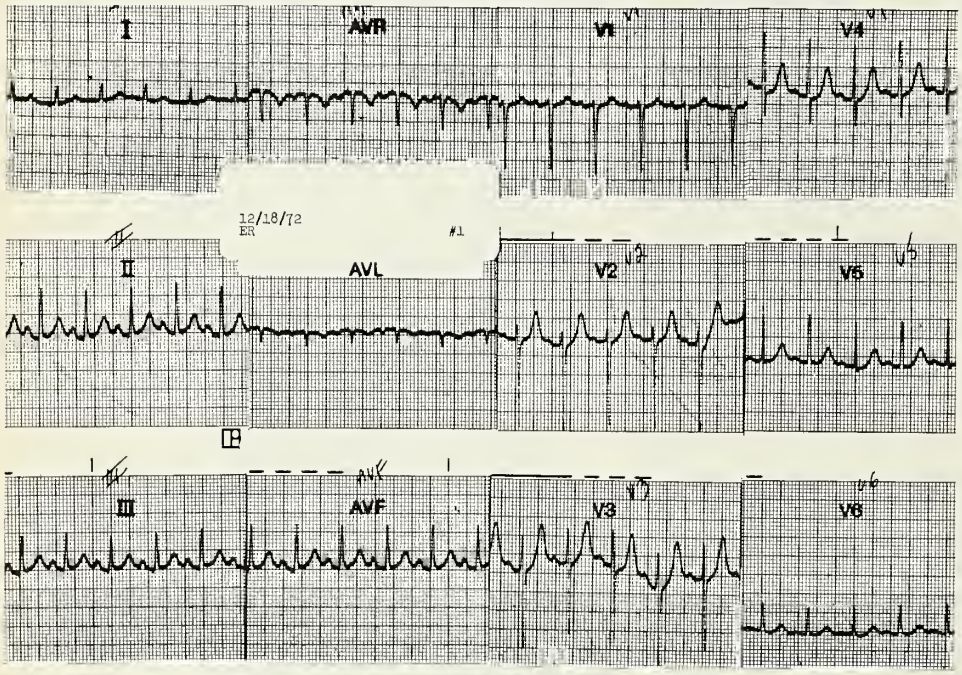
In taking this position do not think I am unaware of the fact that a society that does not move forward quickly deteriorates, indeed, it cannot even survive in a world where everything is in flux. Civilizations can only succeed by exploring the unknown and by accepting the risks of plunging into the future. This does not imply, however, that they plunge blindly into the future with disregard for history and human need. What we are really talking about is change, degree of change, and method of change. Thomas Jefferson, in his wise way, said, "As new discoveries are made, new truths are uncovered and manners and opinions change, with the changes of circumstances, institutions must advance also, to keept pace with the time."

Although recent organizational arrangements remove major portions of environmental pro-

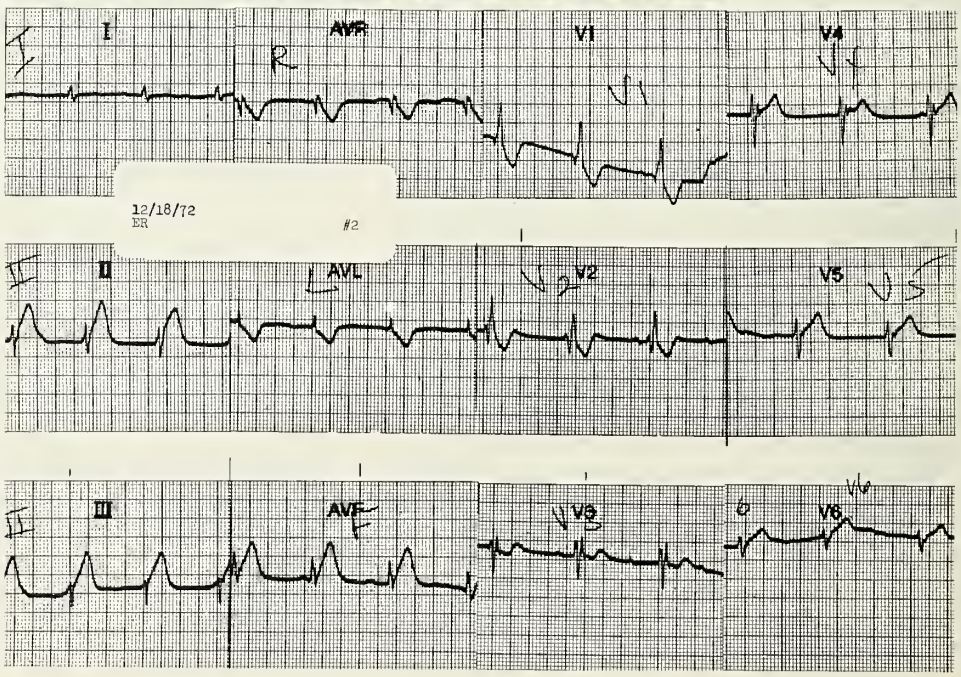
(Continued on page 429)

ekg of the month

John R. Tobin, M.D., M.S., Rimgaudas, Nemickas, M.D., Patrick J. Scanlon, M.D., John F. Moran, M.S., M.D., James V. Talano, M.D., Sarah Johnson, M.D. and Rolf M. Gunnar, M.D., M.S./Section of Cardiology, Loyola University Stritch School of Medicine



EKG #1



EKG #2

EKG (facing page)

This is a 64-year-old white male was was admitted to the emergency room with the onset of severe crushing substernal chest pain for one hour duration. On physical examination the patient appeared disoriented, diaphoretic and restless. A sinus tachycardia was noted; the jugular venous pressure was elevated. Third and fourth heart sounds were heard over the apex of the left ventricle. ECG #1 was taken on admission. One hour after admission a slowing of the heart rate was noted and ECG #2 was taken.

Questions:

1. **The electrocardiogram #1 demonstrates:**
 (a) sinus tachycardia
 (b) an acute current of injury of the anterior wall
 (c) an acute current of injury of the inferior wall
 (d) none of the above
 (e) all of the above
2. **The electrocardiogram #2 demonstrates:**
 (a) sinus rhythm with complete right bundle branch block
 (b) complete AV block
 (c) left posterior hemiblock
 (d) left anterior hemiblock
 (e) A-V dissociation
3. **Relative to the treatment of this patient which of the following statements are true:**
 (a) The patient should be given digitalis and diuretics at once.
 (b) A temporary transvenous pacemaker should be inserted after which digitalis and diuretics may be administered.
 (c) An isoproterenol infusion should be started.
 (d) If hypokalemia is present, KCl solution should be administered intravenously to prevent ventricular ectopics from occurring.

(Answers on page 433)

Man and His Environment

(Continued from page 427)

grams from health departments, public health may not stop its involvement in, or lessen its concern with the problems of environmental quality. Our obligation is clear; we must take positions on environmental health issues. Such positions may not satisfy those who call for a return of the environment to its original uninhabited state. Neither may we accept a policy that allows violation of our natural and human resource for economic or technological gain.

Our standards, and the standards that we support in the political, scientific, and public sectors of our nation, must rest on the following principles:

1. **The standards must be relevant to man. They must be addressed to the prevention and control of health hazards and the improved quality of the environment.**
2. **The standards must be realistic and attainable. They must be attainable within available technology and within reach financially—otherwise they are prohibitions rather than standards.**
3. **The standards must be measurable so that the enforced are able to determine compliance and the enforcer determine when there has been a violation.**
4. **Standards must be aggressive; uncertainties should be resolved in the direction which will protect the public health.**

I am convinced that the problems of our environment may only be considered realistically in terms of "human ecology." There is no doubt but that we have the opportunity now to capitalize on a ground swell of public concern, and we must avoid the error of turning aside from that interest. There have been organizational and political changes that alter program arrangements; they can be corrected if the public health profession asumes an ever-greater public leadership role and establishes an epidemiological and surveillance system that will provide the data upon which environmental policy may be established.

There can be no doubt but that we are desperately late in our efforts at the correction of past environmental degradation. Indeed many argue that population growth alone will prevent adequate correction. However, I am convinced that man can live in harmony with his environment, but it will take every ounce of knowledge and skill at our disposal to make this come true.

Public health has faced major issues in the past. Its leaders and its membership have always risen to the task. I suggest we now face as great a problem in "man and his environment" as we have ever attempted to solve. Let us all pray that we have the wisdom and the courage to face this task and place man in ecological balance with his environment. ◄

A Vasectomy Prosthesis

By Robert T. Bliss, M.D./Cincinnati, Ohio

This true prosthesis replaces sutures, devices, clips, clamps, cautery and valves in the performance of a bilateral partial vasectomy. Reliability in maintaining azoospermia is actually increased while improving the possibility of successful reversal.

The Bliss Vasectomy Prosthesis,** pictured in Figure 1, is made up of two implantable grade stainless steel cuffs, separated by a Polyethylene spreader. The cuffs which crimp onto the vas deferens are deeply knurled on the inside to prevent slippage and wide enough to prevent cutting through the vas, even with moderate crimping pressure. The Polyethylene spreader which holds the two cuffs apart, and in position, is flexible enough to be easily handled and comfortable to the patient, yet stiff enough to maintain the cut ends of the vas apart at all times.

To a dissected intact loop of vas deferens, the prosthesis is applied by crimping the cuffs onto the vas a short distance apart. (See Figure 2.) The segment between the prosthesis cuffs is incised and a portion may be removed for tissue evidence of the surgery. The incised ends automatically will separate at this point but may be easily replaced into anatomical position in the scrotum. (See Figure 3.)

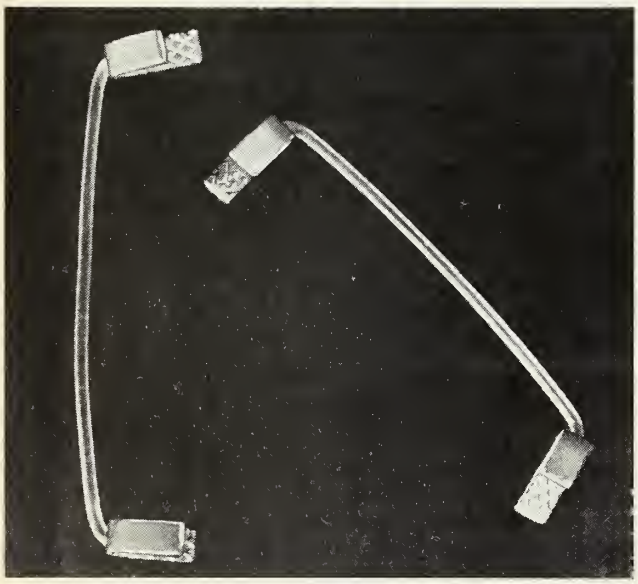


Figure 1



ROBERT BLISS, M.D., is an Assistant Clinical Prafessor of Medicine, University af Cincinnati, College af Medicine. He is a clinician at Cincinnati (Ohia) General Hospital.

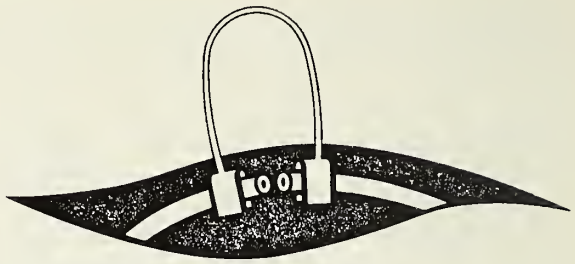


Figure 2



Figure 3

Out of over 100 consecutive cases there have been no reports of patient discomfort. Complications, post operatively, have been minimal and none were actually related to the prosthesis itself. Azoospermia is attained in the usual average amount of time and ejaculations. Repeat sperm count at two and five months have remained zero. X-ray evidence of positioning of the prosthesis at varying intervals up to 5 months have revealed no cases of slippage of the prosthesis cuffs from the ends of the vas deferens. ◄

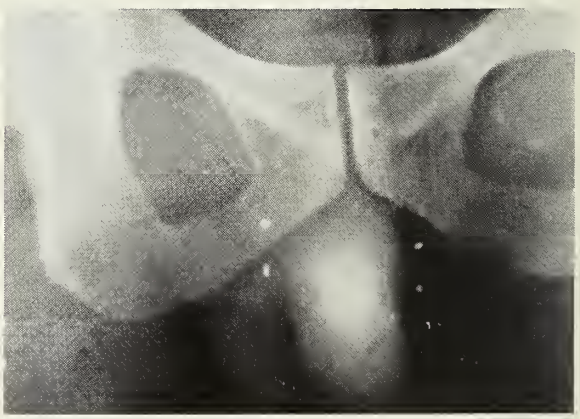


Figure 4

*The Bliss Vasectomy Prosthesis is being produced and distributed by the Xomed® Div., Xomox Corp. of Cincinnati, Ohio 45242.

**Patent Pending.

Perforation of the Colon in the Neonate

By Neil G. Aronson, M.D., Benjamin Emanuel, M.D., and
Paul F. Nora, M.D., F.A.C.S./Chicago

A review of various aspects of neonatal colonic perforation is presented. In addition, **the third surviving case of idiopathic neonatal perforation of the cecum in the American literature is presented.** The importance of early diagnosis, with special attention to rule out distal intestinal obstruction such as megacolon, and rapid institution of appropriate therapy are emphasized.

Although perforation of the gastrointestinal tract of the newborn may be recognized in pediatric centers regularly, published reports of idiopathic perforation of the large bowel, particularly the cecum, are a rarity.[1,2] There is some confusion as to the etiology of the perforation in certain reports.[3,4] However, examination of all previously published cases of neonatal colonic perforation of unknown etiology, excluding necrotizing colitis or patients with distal intestinal obstruction, shows that there have been only three cases of true idiopathic perforation of the cecum, with two survivors.[2,5,7] This paper reviews various aspects of neonatal colonic perforation and reports the third survival of true idiopathic perforation of the cecum in the neonate.

Case Report

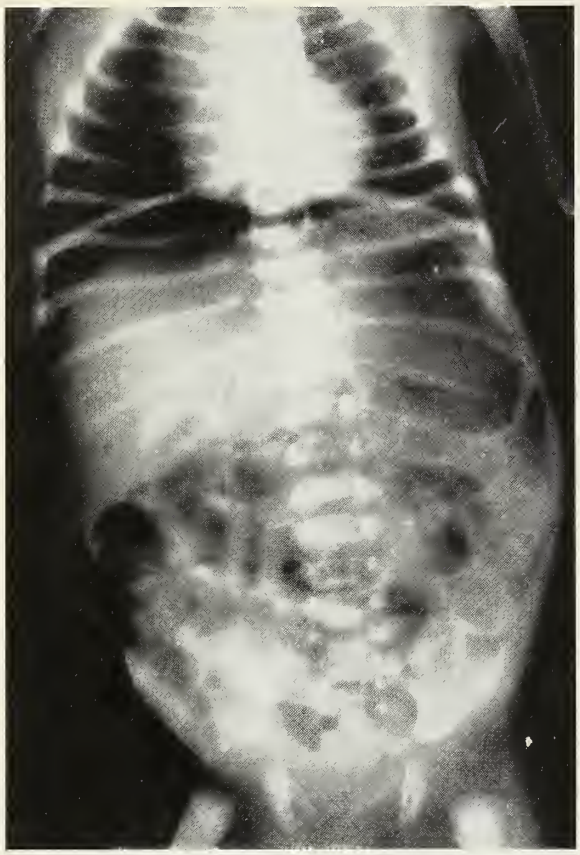
Female baby R.C. was born 8-26-70, birth weight 7 lbs., to a Gravida I, Para 0, blood type O positive, Kahn negative mother at 37 weeks gestation. The mother had been in good health during her pregnancy. The membranes ruptured 30 minutes prior to delivery and the onset of labor was spontaneous. Delivery was by assisted breech. The onset of respiration was immediate and the baby was found to be normal on initial physician examination. By 48 hours of age the infant had not voided for 12 hours and had one episode of regurgitation of yellow mucus.

Two yellowish meconium stools had been passed. Physical examination at that time showed moderate icterus and a distended but soft abdomen with a prominent venous pattern. Bowel sounds were infrequent and low-pitched and a rectal exam was normal. The serum bilirubin was 12.0 milligrams total and 0.7 milligrams direct (this was the highest level of icterus during the entire hospital stay). The hemoglobin was 18.7 grams. The baby's blood type was A+ and the Coomb's test was negative.

The following morning, at approximately 60 hours of age, the abdomen was noted to be increasingly distended although the infant remained active and vigorous. The venous pattern appeared more prominent and fluid was percussed in the abdomen. Lateral decubitus and up-right films of the abdomen were obtained and these showed the presence of air under the diaphragm (Fig. 1). Leucocyte count was 22,000 with 74% polys and 2% stabs. Blood cultures were obtained and blood was drawn for baseline electrolytes and type and cross-match The infant was then prepared for surgery. Surgery was undertaken at about 68 hours of age.

Laparotomy revealed distention of the stomach, duodenum, jejunum, ileum and ascending colon. A whitish fluid was noted in the peritoneal cavity and a small perforation was found in the anterior wall of the cecum. Careful examination of the colon from the hepatic flexure distally showed no abnormalities. Cultures taken

The authors are affiliated with Columbus-Cuneo Medical Center, Northwestern University School of Medicine, Chicago. NEIL G. ARONSON, M.D. and BENJAMIN EMANUEL, M.D., are affiliated with the Department of Pediatrics and PAUL F. NORA, M.D., F.A.C.S., is a member of the Department of Surgery.



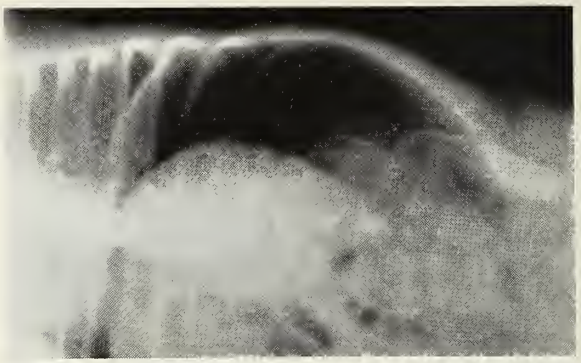


Figure 1. (left) X-rays of patient with perforated cecum: Up-right view which demonstrates free air under the diaphragm; and (top) lateral decubitis, showing marked pneumoperitoneum.

preoperatively from the cord and later from the peritioneal cavity grew Strep. Faecalis and Klebsiella; however, the patient never appeared septic during the entire time in the hospital. Two blood cultures were negative. The perforation was closed with three 4-0 Lembert sutures. The abdominal wound was next closed in layers with interrupted silk sutures.

Following surgery the patient was maintained on intravenous fluids and antibiotics. A Levine tube was removed 12 hours postoperatively and in the second 12 hour period following surgery, the patient passed 4 meconium stools. I.V. Fluids were discontinued on the third postoperative day and oral feedings were resumed.

The immediate postoperative period was without incident. The patient has been followed for approximately one year following surgery. Growth and development have been normal. During the first year of life the patient has had no difficulty with any bowel activity.

Discussion

Perforation of the colon in the newborn is a rare and often catastrophic occurrence Although the site and etiology of some neonatal perforation may be determined preoperatively, in most instances the correct diagnosis awaits laparotomy. Our review of the literature found considerable confusion as to the etiology in some reports. For instance, two previously reported cases of so-called idiopathic perforation of the cecum showed evidence of distal obstruction.[8,9] In one case report the patient had a distal atresia; in the other, the patient had subsequently proven Hirschprung's disease.

Generally, the onset of clinical manifestation is rapid and associated with marked abdominal distention, labored respirations, cyanosis and extreme prostration,[7,9] (our case was associated with a brief period of anuria, early icterus and abdominal distention alone). In other cases bloody diarrhea, vomiting and dehydration have been noted. Many observations have been made concerning the poor correlation of neonatal perforations with septic temperature curves,[2,7,8] (our patient was afebrile). Elevated leucocyte counts in the newborn period are of limited value.[2,7,8]

The differential diagnosis of patients presenting with the above clinical manifestations inculdes: sepsis,[2,7] peptic ulcerations.[7,9] Hirschprung's disease,[9] colonic atresia,[8] imperforate anus,[9] meconium plug,[8,9] vascular obstructions,[5] necrotizing colitis[8] and trauma.[8] In many instances multiple factors may contribute to a given perforation.[2,7,9]

In the above patient there was no evidence of mechanical obstruction or colitis. The uncomplicated postoperative course made the diagnosis of congenital megacolon unlikely. Although positive bacteriological cultures were found, it should be emphasized that the clinical course was never suggestive of sepsis or necrotizing enterocolitis.

It is interesting to speculate as to why there are so few cases of perforation of the cecum in the newborn. In adults with mechanical obstruction retrograde pressure often leads to perforation of the cecum. This has been explained on the basis of increased tension at the cecal area where the diameter of the colon is greatest (tension = pressure $\times \pi \times$ diameter). Perforation of the appendix in the newborn has been associated with megacolon frequently enough to state that neonatal appendiceal perforations are Hirschprung's disease until proven otherwise.[10] There have been no such correlations with cecal perforations. The reason why distal obstruction in the newborn so rarely leads to cecal perforations remains a mystery. Possibly, at this age the ileocecal valve is not as competent as in the adult.

Since almost all patients with perforations have abdominal distention, the X-ray is of central importance in preoperative diagnosis Multiple view abdominal films are essential to demonstrate the presence of pneumoperitoneum.[5] Supine films alone may not be adequate to differentiate between the presence of "free air" and/or dilated loops of bowel. Once the presence of free air in the peritoneal cavity has been demonstrated, the need for immediate surgery is established. Cultures and baseline electrolytes are then obtained, decompression instituted, and intravenous fluids and appropriate antibiotics started. Our choice in the above patient was a combination of penicillin and Kanamycin.

It may be questioned whether simple closure is the preferred surgical treatment. It was the surgeon's opinion in this case, that simple closure was acceptable in this patient, since there was an isolated colonic perforation with minimal contamination and no evidence of Hirschprung's disease or other distal obstruction. We feel that since the patient has been one year postoperative without complications this approach would appear justified. ◄

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EKG of the Month

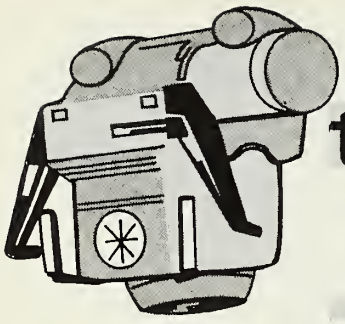
(Continued from page 429)

Answers: *1—a & c, 2—b, 3—b*

In ECG #1 few changes are seen except for sinus tachycardia and an early current of injury in the inferior wall. This would not be obvious without the reciprocal changes seen in the anterior leads. In ECG#2 we see that the patient has now gone into complete heart block with idioventricular rhythm. The pattern of RRBB with a QRS axis seen in ECG #2 indicates that the origin of this escape pacemaker is most probably in the proximal portion of the left bundle before its bifurcation into the anterior and posterior divisions. This would imply transient ischemia of the AV node and HIS bundle. A-V dissociation is not present since the sinus rate is 78, whereas the ventricular rate is 60. This is complete A-V block.

In the past, second degree as complete heart block following an acute inferior myocardial infarction was an indication for a temporary transvenous pacemaker. More recently transvenous pacemaker insertion have been reserved for those patients who develop high degree heart block in the presence of (1) congestive heart failure (2) shock, or (3) an escape ventricular rhythm with a wide QRS complex (>0.11 sec). In this patient a temporary ventricular pacemaker should be inserted.

Caution must be taken in the administration of drugs during complete heart block in acute myocardial infarction. Digitalis should not be administered without a temporary pacemaker because of its pharmacologic effect of depressing conduction in the A-V node. Similarily KCl should not be given during high grade A-V block because it may potentiate the degree of block. Isoproterenol infusion should be reserved for patients with high degree A-V block where the escape rhythm is below 50 beats per minute and the patient is awaiting temporary transvenous pacemaker insertion. ◄



the view box

Leon Love, M.D./Chairman/Department of Radiology
Loyola University Stritch School of Medicine

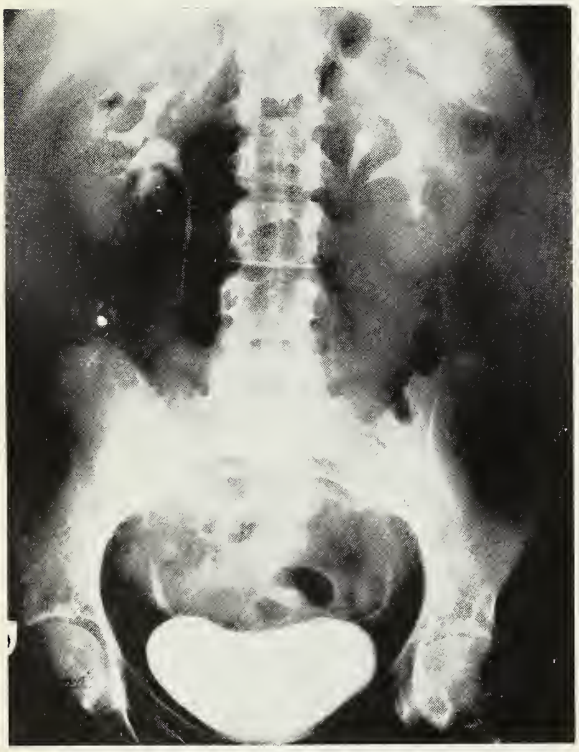


Figure 1

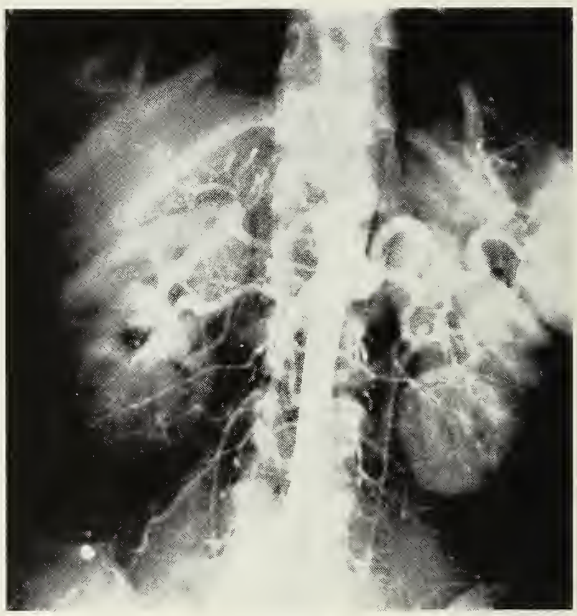


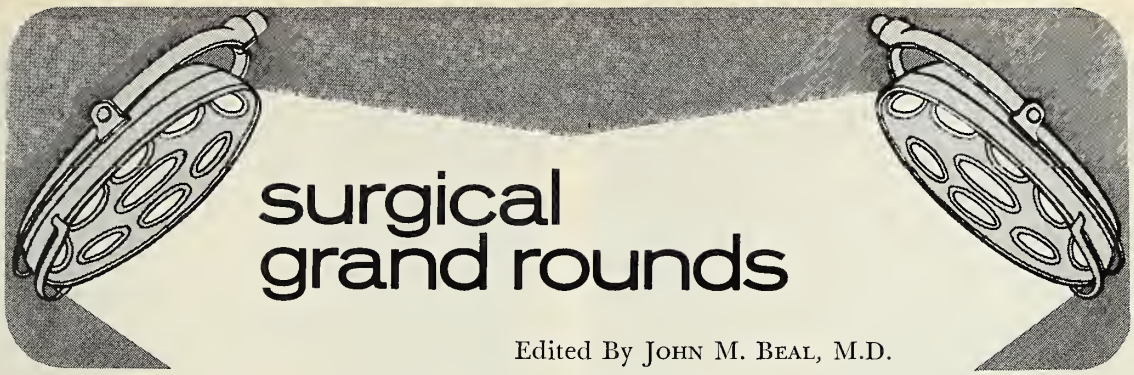
Figure 2

A patient is a 30-year-old female who went to the hospital for a work up for hypertension. Blood pressure was 180/90. The physical findings were essentially normal. The routine laboratory work up showed no abnormalities. An I.V.P. and flush aortogram were done.

What's your diagnosis?

1. Abscess of the upper pole of the left kidney.
2. Cyst of the left kidney.
3. Calyceal diverticula
4. Blind end duplication of a ureter.

(Answers on page 444)



Edited By John M. Beal, M.D.

Pituitary Apoplexy

Surgical Grand Rounds are held weekly on Tuesday at 5:00 P.M. in the Offield Auditorium at Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial and the Veterans Administration Research Hospitals form the basis of the discussion. This case report was part of the Surgical Grand Rounds of February 22, 1972.

Dr. Stanley Carson: A 47-year-old white man was admitted to (Northwestern) Memorial Hospital on January 19, 1971. The patient stated that about a week prior to admission, he had a sudden onset of double vision, weakness of the right eyelid, and pain on the right side of the face. Three days later he had a tooth extraction on the right side and his pain was relieved but his diplopia was still present. Findings at the time of the physical examination then included a third, fourth, and sixth nerve paresis and a bilateral increase in intraoccular pressure. The rest of the examination, including laboratory and radiologic exam was within normal limits except for some sellar calcification. However, the sella turcica appeared of normal size. The patient improved spontaneously within 10 days after admission and was discharged.

This patient was well for one year when he again had the abrupt onset of fatigue, headache, and blurring of vision. One day prior to his present admission, the patient lost consciousness and he was unconscious when admitted to another hospital. After approximately 16 hours, he awoke from his unconscious state and was fairly lethargic. When admitted to Northwestern Memorial on that same day, the patient was without focal signs. The patient was treated with Dexamethasone and 24 hours later was alert. A brain scan was normal. Spinal tap revealed an increased spinal fluid total protein with no increase in cells. Thyroid function was slightly decreased. Angiographic studies were performed and a pneumo-encephalogram was undertaken.

Dr. Abram Cannon: The angiographic studies showed filling in the left carotid and there is filling of the other side by a cross over to the anterior cerebral artery. These vessels are lying on the midline. There is a suggestion of some straightening of the carotid syphon and on the lateral view there is definite elevation of the carotid syphon. A rather dense increase in density along the anterior cerebellum suggests an aneurysm, although it cannot be identified on all films. Certainly this elevation of the carotid suggests a mass in the region of the sella itself. Thus, the angiographic studies are suggestive. When the pneumo-encephalogram is reviewed, one can see air in the basal cisterna which outlines a mass arising in the sella. The dorsum sella is so faint that I really cannot identify it on these films but presumably it was missing on the plain film studies. This is a real good demonstration of a sellar lesion.

Dr. Stanley Carson: A right transfrontal craniotomy was performed on January 17, 1972. A right transfrontal flap was made, was hinged on the temporal muscle and was retracted. The optic nerve was identified. A pituitary mass was found and was excised. During excision we noted that there was an old hemorrhage within the mass. Post operatively, except for mild diabetes insipidus, the patient did well. The visual fields were normal by the 17th post operative day. The patient was discharged with maintenance doses of cortisone and thyroid.

Dr. Joseph Sherrick: The tumor was composed of medium-sized cells with relatively clear cytoplasm, arranged in little groups by a delicate stroma. In Figure 1, erythrocytes are scattered



Figure 1. Angiographic study shows elevations of carotid artery, compatible with pituitary tumor.



Figure 2. Pneumo-encephalogram demonstrated mass in region of pituitary.

throughout the tumor. The tumor cells do not contain granules, and the appearance is consistant with a chromophobe adenoma of the pituitary, with degeneration and hemorrhage consistant with the clinical diagnosis of pituitary apoplexy.

Dr. Stanley Carson: Of tumors that occur within the cranium, those of the pituitary account for about 12%. Adenomas of the pituitary predominate and the majority are chromophobe, that is they take up stains poorly. Other tumors of the pituitary are rare. Tumors of the pituitary ordinarily come to the attention of the patient or his physician because of a change in endocrine function. One example is the change in secretion of growth hormone which results in gigantism.

One of the most prominent symptoms is headaches. One of the least common symptoms is pituitary apoplexy which occurs in approximately 3% of pituitary tumors. Pituitary apoplexy has an abrupt onset, most commonly with culminating confusion or coma. In cases where autopsy has been performed, hemorrhage or extensive necrosis of an adenoma, or occasionally a craniopharyngioma has been found.

The differential diagnosis includes acute adrenal insufficiency which can give the same picture. Therefore, skull X-rays should be obtained to demonstrate the sella turcica and it is wise to obtain base line estimates of endocrine function.

Treatment of a patient with a pituitary apoplexy has varied. Surgical intervention has been recommended. Others have proposed radiation or operation followed by radiation. The mortality rate associated with surgical therapy has a wide reported range with an average of approximately 2.5%. Following operation, visual recovery is variable. It is interesting to note that most of the visual recovery occurs within the immediate post operative course. Of those patients who do have recovery of vision, approximately one-third have complete recovery. Patients treated by radiation alone have a wide range of functional recovery.

Dr. Nicholas Wetzel: This patient is of interest from two standpoints: 1) the rarity of the lesion, and 2) the mode of presentation. Another aspect is interesting. We have documented radiologically an increase in size of the sella from growth of the pituitary tumor, in one year. This patient was seen a year ago, when he had been referred with a diagnosis of carotid-cavernous sinus fistula. When he was examined, none of the signs of a carotid-cavernous sinus fistula, namely a proptosis and chemosis were found, but merely a third cranial nerve palsy. The presence of some calcifications around the sella were interpreted as being just carotid calcifications in a 47-year-old man. He improved spontaneously and hence further studies were not done. I'm a firm believer of not "rocking the boat" if the patient is getting well. He was not seen again until he again appeared in the Emergency Room after this sudden onset of apopletic symptoms.

The usual patient who has pituitary apoplexy has had the diagnosis of a pituitary adenoma made and then has had a sudden worsening of his symptoms, particularly as far as their vision is concerned. As Dr. Carson has said, many have thought this to be an acute emergency that was

needed to be dealt with immediately. This patient improved immediately with the administration of steroids although the diagnosis was not entirely obvious. Bilateral carotid angiography was performed to determine if an aneurysm was present. In addition, his visual field changes were atypical of a pituitary tumor. Typical findings in a pituitary tumor are those of a lesion producing bi-temporal hemianopsia. He had a left hemianopsia which was confusing and contributed to the delay in diagnosis. With replacement therapy, his general improvement created a problem.

This man is a lawyer and he began to wonder why he needed an operation. However, his marked visual field loss remainded. It was our feeling that, should we have treated him with radiation, his vision might have worsened even further with the swelling associated with radiation therapy. Accordingly, operation was performed. As I incised the caspule of the tumor, a considerable flow of dark old blood welled up, much as one would see in a subdural hematoma, and I think that perhaps I could have almost stopped then because most of his tumor had been destroyed by the hemorrhage. Of course, it is possible that had we not operated on him, with the absorption of the blood clot, he would have improved. He has improved very gratifyingly. He feels well with his replacement therapy and is doing well. **One of the great contributions to surgery of the pituitary has been steroid therapy.** The morbidity and mortality of operations on patients who were in hypopituitary state was high before steroids were available. These patients tolerated surgery very badly, usually had a very stormy post operative course including such problems as hyperthermia. The steroids, plus the modern anesthesia and the osmotic dehydrating agents have made surgery in this area much safer than it was 15 to 20 years ago.

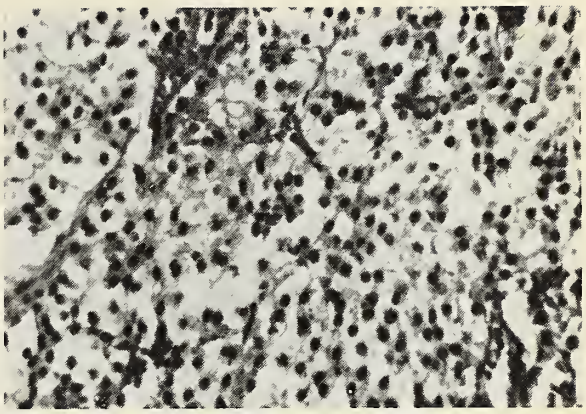


Figure 3. Chromophobe adenoma of pituitary showing recent hemorrhage.

Dr. John Beal: Does pituitary apoplexy occur only in pituitary tumors?

Dr. Nicholas Wetzel: This is somewhat similar to a Sheehan's syndrome which is post partum pituitary necrosis, either due to a thrombosis or hemorrhage into the pituitary, and seldom, if ever, occurs in a normal pituitary gland. It almost always occurs in patients with pituitary adenomas. ◄

Infection Improves Cancer

A retrospective chart study revealed improved survival rates in patients in whom empyema developed after surgical resection for carcinoma of the lung. The overall five-year survival rate for the empyema group of 18 patients was 50%, compared to an 18% five-year survival rate in a control group consisting of a random 34-patient sample of resected cases at this institution. On further analysis, the beneficial effect of intrapleural infection was found principally in patients with tumor limited to the lung and its draining regional lymph nodes. Six of seven patients in this group survived for five years.

The protection from recurrent cancer conferred on these patients by postoperative empyema may have been mediated by the activation of regional cellular immune mechanisms. The reaction between immune lymphocytes and bacterial antigens is believed to release lymphokines and activate macrophages that nonspecifically destroy residual tumor cells while containing the intrapleural infection. (John C. Ruckdeschel et al.: "Postoperative Empyema Improves Survival in Lung Cancer." *New England Jl. Med.* (Nov. 16) 1972, pgs. 1013-1017.)

Concepts of Management in Infertility

By Ronald E. Burmeister, M.D./Rockford

The diagnosis and treatment of the infertile couple provides the interested gynecologist with a genuine medical challenge. The incidence of infertility in couples having frequent intercourse is about 10-15% after the first year of marriage. Although most studies agree that the over-all success rate of treatment is still about 50%, with proper management of selected cases the physician may be able to restore fertility with a minimum of time and effort.

However, proper therapy must be predicated on an accurate diagnosis, and the accompanying table outlines the principal tests required for the average sterility investigation. This list stresses the obvious underlying theme of the infertility survey: the lack of a pregnancy means a failure in reproductive physiology. The purpose of the investigation is threefold: 1) to find a clinical explanation; 2) to establish a diagnosis; 3) to offer a prognosis. Herein, then, lies the charge of this subspecialty, and within this framework several comments can be made regarding the management of this interesting group of patients.

The couple that has been denied the physiological capacity to reproduce usually presents with many anxieties borne from frustration. Oftentimes the wife has been told for years to "just relax, your pelvic examination is normal," until she finally sublimates her misgivings into adoption or resigns herself to her infertile state. When she does consult the infertility specialist, she may have passed the prime childbearing years. Women who complain of intermittent diarrhea, dyspareunia, and dysmenorrhea commonly are consigned to the diagnoses of spastic bowel syndrome, frigidity, or psychoneuroses, respectively, without consideration of the possibility of endometriosis. Patients with gross irregularities in their menstrual cycles are not all emotionally immature; they may have serious disturbances of hypothalamic-pituitary, ovarian, or adrenal metabolism. In some cases, the duration of infertility may be relatively short. If obvious disease is detected either from the history or physical findings in a patient recently married, there is no magic in the "wait-and-see-for-one-year" tradition. Thus, the gynecologist must listen to the history of the chief complaint in the context of reproductive pathology rather than reproductive normalcy.

Since sterility may be the presenting symptom of a number of underlying diseases, a careful physical as well as pelvic examination must be performed and appropriate laboratory studies ordered. The history and physical findings should be discussed with both patient and her husband in terms of the projected fertility evaluation. Education of the couple is an integral part of diagnosis and therapy, and for this reason, the husband should be encouraged to accompany his wife to the office several times during the investigation. A male factor is present in 20-40% of infertile couples; therefore, the husband must necessarily be familiar with all objectives of the work-up. Since some men equate oligospermia with decreased masculinity and impotence, both the gynecologist and urologist must function in advisory, as well as therapeutic, capacities for the husband.

From 15-30% of infertile patients will become pregnant during the testing period and the physician should allow sufficient time intervals between procedures for this possibility. However, the anxiety level of the couple must be continually assessed to prevent discouragement, and the length of the evaluation therefore governed accordingly. If necessary, all of the tests listed in the table can be performed within a two-month period without difficulty. Since there are often multiple factors contributing to infertility, the physician should not conclude



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the evaluation when one determination is found to be abnormal. It must be stressed that prolonged workups over an extended period of time are not relevant to the aggressive management of infertility.

Occasionally, adjustments must be made in coital technique and frequency at mid-cycle. The physician should discuss necessary changes in intercourse patterns without raising anxieties in the couple. The patient may be reluctant to admit that her husband has relative impotence when coitus-on-demand is required at mid-cycle. The gynecologist should make specific inquiry about this possibility and not only reassure her, but instruct the patient in the various subterfuges available to her to circumvent the problem.

A sterility investigation is not complete without visualization of the female pelvic viscera, and this can be readily accomplished with the fiber optic endoscopy equipment now available.

Although culdoscopy has been popular in the past, many experts now consider laparoscopy to be the diagnostic method of the choice. Either procedure will detect additional pelvic pathology, otherwise not suspected, in 30-40% of cases, such as endometriosis, peritubular adhesions, and anovulatory ovaries. But the endoscopic procedure does not negate the value of the other tests, each of which has its own importance. A dilatation and curettage is essential and is performed with endoscopy, thus eliminating the painful endometrial biopsy; when obtained between days 21-25, the endometrium can be accurately dated.

Summary

In summary, infertility represents reproductive pathology; a systematic diagnostic armamentarium is available; a specific treatment program can be formulated based on the diagnosis and a prognosis offered. The gynecologist must remain sympathetic and alert to the emotional needs of the couple during evaluation and therapy. Whether the physician is successful or fails in his efforts to achieve a pregnancy, the infertile couple will be most grateful ◄

The Essentials of an Infertility Investigation

1. Basal body temperature chart
2. Sperm count and sperm agglutination
3. Huhner test and cervical mucus evaluation
4. Hysterosalpingogram
5. Appropriate endocrine studies
6. D&C, endoscopy

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Business Troubles in the United States

The growing public disenchantment with business in this country, and with big business and impersonal business in particular, is worrying the Businessmen. One businessman told a national conference of his peers that unless something dramatic was done to arrest the trends he feared that the public might demand the dismantlement of big business during the next five years. Another growing tendency is to sue firms selling faulty products, and business is now suffering (in the same way that medical men and women have suffered over medical malpractice litigation) from ever higher awards, even higher premiums, higher deductibles (that is, the uninsurable amount), reluctance of insurance companies to provide cover, and so on.

Perhaps this mounting attack on business is the counterpart of the mounting disillusionment with government at all levels, and the feelings of helpless impotence and rage when faced with an essentially impersonal bureaucracy. Of course, physical assault is one means of venting this rage, and welfare officials, at least in the lower echelons, seem to be particularly at risk; but behind businesses there are people who individually or corporately can be sued, and being sued they are, and for increasingly large sums. A person these days who suffers injury from a faulty product is not likely to take it lying down, but will go to the courts and seek ample compensation. This is being done in record numbers, and the costs to business are rising astronomically. Part of this increased litigation is due to an alteration in the law, or rather to the legal interpretation of the doctrine of "strict liability." The interpretation is being extended on the one hand to benefit not only those actual users of a defective product but also any bystanders or others who may be secondarily involved, and on the other to involve not only the manufacturers but also everybody concerned in the selling of a product to the consumer. No wonder business and the insurance companies are getting scared. It will be interesting to see whether the federal government will intervene, and to what extent. Big business has more friends in government circles than the doctors have. ("Business Troubles with the Courts." *The Lancet,* Vol. 11, Nov. 18 1972, pg. 1076.)



medical legal review

Emergency Room Procedures

By James L. Fletcher, ISMS Legal Counsel

I. What Duty Do Public and Private Hospitals Have With Respect to the Admission of Persons Presenting Themselves at an Emergency Room for Treatment?

Under Illinois law, all hospitals, that are required to be licensed by the Department of Public Health, which provide general medical and surgical hospital services ". . . shall provide a hospital emergency service in accordance with rules and regulations adopted by the Department of Public Health and shall furnish such hospital emergency services to any applicant who applies for the same **in case of injury or acute medical condition where the same is liabel to cause death or severe injury or serious illness.**" (Chapter 111 1/2, Section 86, *Ill. Rev. Stat.*, 1972)

It should be emphasized that, according to Section 86, quoted above, hospital emergency service must be provided:

1) In accordance with rules and regulations adopted by the Department of Public Health; and

2) In the case of an injury or acute medical condition which is liable to cause death or severe injury or serious illness.

Both of the above quoted standards should be adhered to whenever a hospital is considering offering its facilities to an emergency admittance. The implications of this statutory language are many and few courts have been called upon to interpret its scope and intent.

A leading case on this subject is *Bourgeouis v. Dade County,* 99 So. 2d 575, 72 A.L.R. 2d 391 (Florida Supreme Court, 1957). In that case, a hospital refused admittance to a man, whom hospital personnel felt was merely drunk but who later died from a puncturing of the chest cavity by broken ribs. The Florida Supreme Court held that the decision not to treat the man was subject to ordinary standards of medical care. Although the Court did not specify the standards applicable to this situation, it is clear that the hospital would have to justify both its screening procedures and the decision made pursuant to those procedures.

The rationale of the Florida Court seems applicable to Illinois. In observing the Florida guidelines, each hospital should employ the best screening procedures possible. If no medical emergency exists, no treatment is statutorily required to be undertaken; but a hospital is responsible for using reasonable medical procedures in determining whether an emergency does exist. The Illinois Department of Public Health is empowered to establish rules pursuant to the Medical Emergency Treatment Act. Each hospital should obtain and observe these standards strictly.

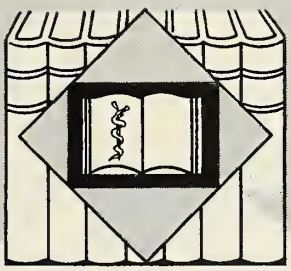
II. What Duty Does a Doctor on Emergency Room Duty Have to Admit and Treat a Patient Requesting Emergency Care?

Generally speaking, only a physician is authorized to admit persons to a hospital. Although other personnel may screen out potential patients, a doctor's approval is necessary for admittance. Refusal by a physician to admit a patient must be justified by medical standards. In the case cited above, the Court specifically stated:

"The attending physician must use the judgment to form the opinions of one possessed of knowledge

(Continued on page 444)

the doctor's library



Contribution to Neuropsychology. Edited by Arthur L. Benton. (Aldine-Atherson Publishing Company, Chicago, 1969.) Numerous tables and illustrations and 239 pages. Price: $8.50.

Clinical neuropsychology, a new field, is a paradiscipline developing with unusual speed in the past 25 years. As a result, there is emerging a much clearer, a more advanced understanding, even an interpretation of the complex interrelationship that exists between brain functioning and correlative human behavior.

In this small tome is incorporated contributions from eight of the world's foremost authorities who draw from their findings of their own specific clinical studies, their conclusions through animal experimentation, and their other observations all made within flexible approaches. Understandably, each contributor, a widely experienced leader in the field of human and developmental neuropsychology presents his own specific topic of endeavor.

Dr. Klaus Preck leads with the chronologic development of the topic of neuropsychology and brings the reader up-to-date on what is new. Both Drs. George Ettlinger and Colin B. Blakemore discuss the behavioral changes both in animals and in humans. After commissural section, Dr. Sidney Weinstein presents neuropsychological studies in humans with "phantom" phenomena. Dr. Norman Geschwind, acknowledged as the foremost authority in the field of aphasia, presents his interesting theories of the anatomic approaches to this complex problem. Dr. Arthur L. Benton, the editor of this small book, presents the many unanswered questions concerning constructional apraxia.

Next, Dr. Josephine Semmes surveys her thoughts concerning protopathic and epicritic sensation, a truly brilliant presentation and a classic model from which to formulate. Dr. Luigi A. Vignoli, a pioneering investigator, examines and reviews almost 40 years of thinking on auditory agnosia, adding his own thoughts and inclusions of his own research on this major inquiry.

This small tome, the subject of a series of lectures by this distinguished group of brilliant investigators more than fulfills its promise of shedding new light on subjects heretofore only theoretic, but now more clearly understood through insight developed by productive research

Louis Boshes, M.D.

* * *

Hematologic Problems in the Newborn. By Oski and Naiman. Published in 1972 by W. B. Saunders Company.

This book was a pleasure to review. Having extensively used the first edition of this book, I looked forward with great anticipation to the revised second edition. If the current knowledge of hematologic problems of the newborn had to be put into a nutshell it would have to be just about the size of this book.

The nutshell has grown. A new chapter on "Polycythemia in the Neonatal Period" has been added, the other chapters have been thoroughly revised and updated. Nearly 50 pages of up to date bibliography form the backing. The basic knowledge and principles of diagnosis and therapy are presented in a very concise, clear and eminently readable fashion. They form a sound foundation for an understanding of the hematologic problems of childhood. For this reason this book should be widely recommended to anyone interested or involved in the care of newborns and children, including obstetricians, family practitioners and pediatricians.

Edda H. Hackl, M.D.

Editorials

Non Licensed Physicians

According to a survey conducted by the office of the New York State Attorney General, Louis J. Lefkowitz, "Up to 13% per page" of those listed as "Physicians and Surgeons, M.D." in the Yellow Pages are not licensed to practice medicine in the State of New York. Approximately 9% listed in the Manhattan directory were unlicensed; 13.8% in Brooklyn, and 7% in Nassau. A similar survey in the larger cities of Illinois should be conducted to determine if we have the same situation.

The Bell System cannot be blamed because they do not screen the credentials of those listing themselves as professionals in the telephone directory. It is possible that some of those listed, but unlicensed, are medical administrators, full-time faculty members at medical schools, or doctors in government medicine. We will be interested in the follow-up survey in New York. Meanwhile, it might be wise for us to conduct a similar study.

T. R. Van Dellen, M.D.
Editor

Many Listed in Yellow Pages as MDs Found to be Phonies. *Medical Tribune* (Jan. 24) 1973.

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J. Herbert Maltz, M.D., Medical Director

Chicago Lakeshore Hospital

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Emergency Room Procedures

(Continued from page 440)

and skill common to medical men practicing in the same or similar communities."

Once admitted, that doctor is bound to render reasonable medical care to that person until 1) the need for care ceases, or 2) another physician assumes care of the patient.

III. What Duty Does a Hospital Have to Permit Patients Admitted On an Emergency Basis to Continue to Utilize Their Facilities?

The hospital's obligation runs with that of the physician. As long as a doctor affiliated with the hospital continues to treat the patient, the hospital must permit him to use their facilities. Individual hospital bylaws may provide specific guidelines implementing this principle.

IV. What Obligation Does a Physician Have to Serve on Hospital Emergency Room Duty

This obligation is governed by contract between the hospital and the physician.

V. Will Area Wide Emergency Plan Legislation Alter the Duty of Hospitals and Physicians With Regard to Emergency Care?

While the legal obligation of all hospitals to provide emergency care will not be eliminated from Illinois statutes, area wide plans will rationalize the use of emergency services and thereby minimize the practical difficulties associated with it. ◄

View Box

(Continued from page 434)

Diagnosis: *Blind end duplication of a ureter* which in effect is a ureteral diverticula. Embryologically the ureteral bud arises posterior to the Wolffian duct and usually meets the nephrogenic blastoma in the sixth week of fetal life. Splitting of the ureteric bud as it grows into the blastoma results in various duplications of the kidney and ureter, and as in this case, a ureteric bud which blind ends. The angiogram revealed that there was normal kidney substance with vascular supply of the area involved. Usually these are asymptomatic and are incidental findings which are extremely rare. ◄

★

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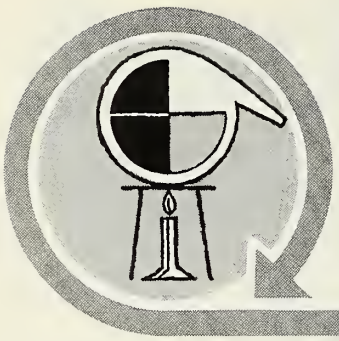
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new pharmaceutical specialties

By Paul Dehaen

For detailed information regarding indications, dosage, contraindications and adverse reactions; refer to the manufacturer's package insert or brouchure.

Single Chemicals: Drugs not previously known, including new salts.

Duplicate Single Drugs: Drugs marketed by more than one manufacturer.

Combination Products: Drugs consisting of two or more active ingredients.

New Dosage Forms: Of a previously introduced product.

The following new drugs have been marketed:

SINGLE CHEMICALS

HYPERSTAT I.V. Hypotensive ℞
Manufacturer: Schering Laboratories
Nonproprietary Name: Diazoxide
Indications: Emergency reduction of blood pressure in malignant hypertension in hospitalized patients.
Contraindications: Compensatory hypertension
Precautions: Careful supervision of the patient
Adverse Reactions, Overdosage, and Drug Interactions: Refer to package insert
Dosage: Given intravenously; follow instructions in package insert. Do not administer intramuscularly or subcutaneously.
Supplied: Ampules, 20 cc./300 mg.

DUPLICATE SINGLE DRUGS

REMSED Mild Hypnotic ℞
Manufacturer: Endo Laboratories, Inc., Garden City, New York
Nonproprietary Name: Promethazine HCl
Indications: Daytime sedation, mild insomnia and preoperative sedation
Contraindications; Warnings and Precaution: See package insert
Dosage: Daytime sedation—12.5 to 25 mg. 3 to 4 times daily; Hypnosis—50 mg. at bedtime; Preoperative—25 to 50 mg.
Supplied: Tablets, 25 to 50 mg. Syrup, 12.5 mg./5 cc.

TINIC Vitamin Prep. ℞
Manufacturer: S. J. Tutag & Co., Detroit, Mich.
Nonproprietary Name: Nicotinic Acid
Indications: Nicotinic acid deficiency and conditions associated with deficient peripheral circulation.
Contraindications: Severe hypertension and hemorrhaging, peptic ulcer, impaired liver function and severe diabetes.
Caution: In glaucoma
Dosage: One timed release capsule daily
Supplied: Capsule, 400 mg.

COMBINATION PRODUCTS

CORAMED Cold Preparations o.t.c.
Manufacturer: Buffington, Cambridge, Mass.
Composition:

Aspirin	5 gr.
Clorpheniramine Maleate	2 mg.
Caffeine	½ gr.

Indications: Discomfort and aches of the common cold
Dosage: As directed
Supplied: Tablets

ENDECON Cold Preparation o.t.c.
Manufacturer: Endo Laboratories, Inc., Garden City, New York
Composition:

Acetaminophen	325 mg.
Phenylpropanolamine HCl	25 mg.

Indications: Relief of nasal congestion and pain and fever in the common cold or flu.
Precaution: Use with caution in high blood pressure, heart or thyroid disease.
Drug Interaction: MAO inhibitors and antidepressant drugs
Dosage: Initially two tablets, followed by 1 or 2 tablets q.i.d.
Supplied: Tablets

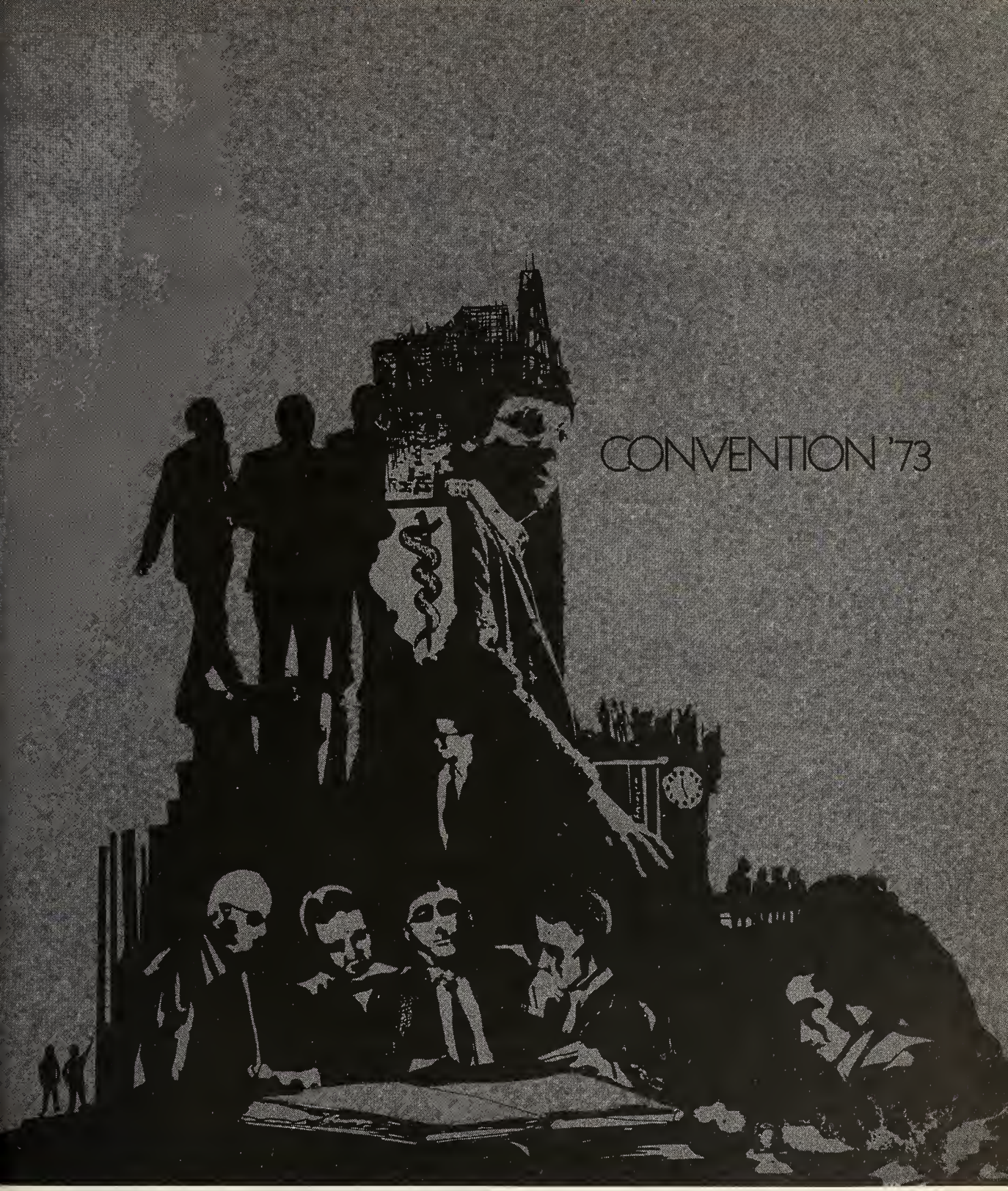
OXYQUIN Dermatological Prep. ℞
Manufacturer: Moore-Kirk Laboratories, Inc., Oakmont, Pa.
Composition:

Iodochlorhydroxyquin	3%
Hydrocortisone	1%

Indications: Infectious and inflammatory disorders of the skin.
Contraindications: Do not use in the eye or topically in the presence of tuberculosis or viral skin conditions.
Dosage: Apply small amount to affected area t.i.d. or q.i.d.
Supplied: 20 gm. tubes.

NEW DOSAGE FORM

MESTINON Injectable Parasympathomimetic ℞
Manufacturer: Roche Laboratories, Nutley, N.J.
Nonproprietary Name: Pyridostigmine bromide
Indications: Myasthenia gravis and antagonist to nondepolarizing muscle relaxants.
Contraindications: Hypersensitivity, intestinal and urinary obstructions of mechanical type.
Precautions: Refer to package insert
Dosage: Refer to package insert
Supplied: Ampules, cc./5 mg. ◄



NEW OFFICERS & TRUSTEES
HIGHLIGHTS OF CONVENTION
SUMMARY OF HOUSE ACTIONS

Illinois State Medical Society
1973-74 Officers
and
Board of Trustees

Officers

PRESIDENT	Willard C. Scrivner, 6600 W. Main, Belleville 62223
PRESIDENT-ELECT	Fredric D. Lake, 1041 Michigan Ave., Evanston 60202
1st VICE PRES.	Paul W. Sunderland, 214 N. Sangamon St., Gibson City 60936
2nd VICE PRES.	Charles J. Weigel, 7579 Lake St., River Forest 60305
SEC.-TREAS.	Jacob E. Reisch, 1129 S. 2nd St., Springfield 62704

House of Delegates

SPEAKER	Andrew J. Brislen, 6060 S. Drexel Blvd., Chicago 60637
VICE-SPEAKER	James A. McDonald, 13 S. 2nd St., Geneva 60134

Trustees

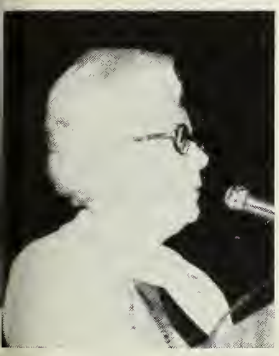
1st Dist.	1974	Joseph L. Bordenave, 1665 South St., Geneva 60134
2nd Dist.	1974	Allan Goslin, 712 N. Bloomington, Streator 61364
3rd Dist.	1976	David S. Fox, 20829 Greenwood Center Ct., Olympia Fields 60461
	1976	Robert T. Fox, 2136 Robin Crest, Glenview 60025
	1975	Eugene T. Hoban, 6429 North Ave., Oak Park 60302
	1975	Joseph H. Skom, 707 Fairbanks Ct., Chicago 60611
	1974	William M. Lees, 6518 N. Nokomis, Lincolnwood 60646
	1974	George Shropshear, 1525 E. 53rd, Chicago 60615
	1974	Philip G. Thomsen, 13826 Lincoln, Dolton 60419
	1976	Frederick E. Weiss, 15643 Lincoln, Harvey 60426
	1975	Warren Young, 3450 Haweswood Dr., Crete 60417
4th Dist.	1976	Fred Z. White, 723 N. 2nd St., Chillicothe 61523
5th Dist.	1976	A. Edward Livingston, 326 Fairway Dr., Bloomington 61701
6th Dist.	1975	Mather Pfeiffenberger, State and Wall St., Alton 62002
7th Dist.	1976	Arthur F. Goodyear, 142 E. Prairie, Decatur 62523
8th Dist.	1976	Eugene P. Johnson, P.O. Box 68, Casey 62420
9th Dist.	1975	Warren D. Tuttle, 203 N. Vine St., Harrisburg 62946
10th Dist.	1975	Herbert Dexheimer, 301 S. Illinois, Belleville 62220
11th Dist.	1974	Joseph R. O'Donnell, 444 Park, Glen Ellyn 60137

Chairman of the Board	William M. Lees, 6518 N. Nokomis, Lincolnwood 60646
Trustee-At-Large	Frank J. Jirka, 1507 Keystone, River Forest 60305



Tribute to
Retiring ISMS
President
FRANK J.
JIRKA, JR., M.D.

1973 Convention Highlights



Mrs. Willard C. Scrivner, ISMS First Lady



Mrs. Robert Hartman was installed as the 1973-74 President of the Woman's Auxiliary.



WILLARD C. SCRINVER, M.D., (left) OB-GYN specialist from Belleville, is inducted as the new leader of ISMS by Frank J. Jirka, Jr., M.D., Past-President



Dr. Scrivner teams up with newly elected President-Elect, FREDRIC D. LAKE, M.D., a Chicago radiologist

Over 4,000 at Convention and Clinical Conference

The 133rd Annual Meeting of the Illinois State Medical Society and the Midwest Clinical Conference was attended by more than 4,000 physicians, Woman's Auxiliary members, exhibitors, medical students and visitors. More than half the attendees were physicians.

House of Delegates Attendance

The Committee on Credentials reported the following attendance for the 133rd annual meeting of the ISMS House of Delegates:

1973	Off. & Trustees	Speaker & V.S.	DS	CMS	SAMA
1st Session (49 counties)	23	2	66	48	1
2nd Session (55 counties)	19	2	82	59	1
3rd Session (55 counties)	22	2	79	56	1

Illinois Delegation to AMA Introduced

During the first session of the House of Delegates the Illinois delegation to the American Medical Association was introduced by Carl E. Clark, Chairman of the delegation. Serving as AMA delegates are: Drs. Jack L. Gibbs, Theodore Grevas, H. Close Hesseltine, Maurice M. Hoeltgen, Joseph R. Mallory, Morgan M. Meyer, Edward A. Piszczek, Harold A. Sofield, Philip G. Thomsen and Theodore R. Van Dellen.

Past Presidents Gather for Convention



Past Presidents of ISMS gathered on the eve of the annual meeting for a formal dinner. C. J. Jannings, III, M.D., immediate Past President, was honored at the dinner. Dr. Jannings received a dinner plate that had the names of the Past Presidents in attendance. Jacob E. Reisch, M.D., ISMS Secretary-Treasurer hosted the event.

Pictured are: (left to right) Arbell Vaughn, M.D.; C. J. Jannings, III, M.D.; J. Ernest Breed, M.D.; Leo P. A. Sweeney, M.D. and E. P. Coleman, M.D.

Back row: Edward W. Cannady, M.D.; Caesar Portes, M.D.; Newton DuPuy, M.D.; Jacob E. Reisch, M.D.; H. Close Hesseltine, M.D.; Edward A. Piszczek, M.D. and Harlan English, M.D.

Illinois Physician Recognized For Viet Nam Service



John Garnello, M.D., (left) retired physician, was presented with a special award for his five tours of two months each as an AMA Volunteer Physician to Viet Nam. Charles Weigel, M.D., President of Chicago Medical Society, made the presentation.

Memorial Service Conducted

During the first session of the ISMS House of Delegates, Jacob E. Reisch, M.D., Secretary-Treasurer, called upon the House to observe a moment of silence to remember deceased ISMS members. Special mention was made of the passing of a Past-President, James D. Hutton, M.D. Throughout the year the Secretary-Treasurer sends condolence letters to the families of the deceased.

Membership Status Changed for 86

The House of Delegates approved the status change of 86 members. Of this total 18 were emeritus; 47 were retired and 21 were exempt for cause. It was explained that to qualify for emeritus standing, the member must have been a regular member for 35 years.

WA/AMA President and President-Elect in Attendance

Special guests included Mrs. Robert F. Beckley, President, Woman's Auxiliary to the American Medical Association and Mrs. Willard C. Scrivner, President-Elect to WA/AMA. Mrs. Beckley gave a frief synopsis of the purpose of the Woman's Auxiliary. She told of the efforts being made to improve the image of health education. The Woman's Auxiliaries also raise funds for medical scholarships and encourage people to join medical fields.



Mrs. Robert Beckley

"A New Foundation"

"We must begin to lay a new foundation for our profession," stated Frank J. Jirka, Jr., M.D., during his President's Address to the ISMS House of Delegates. Dr. Jirka called for REALITY, STRENGTH, FACT and TRUTH on which to build this new foundation. Because organized medicine and the medical profession are facing rapid change, Dr. Jirka called upon the assembly and county societies to act NOW!

Dr. Jirka stressed that "individualism" today is destroying organized medicine's efforts. Through the visual effects of a film and in his conclusion, Dr. Jirka pointed out how the individual needs to take time to look at himself and to learn to listen and work with others.

Frank J. Jirka, M.D. Honored At President's Night

Friends, medical colleagues, ISMS members and the Woman's Auxiliary gathered to pay tribute to retiring ISMS President, Frank J. Jirka, Jr., M.D. at the Tuesday evening President's Night. Dr. William M. Lees, Chairman of the Board of Trustees, served as emcee for the evening.

Dr. Jirka was presented with a scrapbook of his activities compiled by the ISMS Public Relations Department.

Entertainment for the evening was provided by the outstanding Franz Benteler, His Stradivarius and Violins.

AMA Officers Address ISMS Assembly

Special guests in attendance included C. A. Hoffman, M.D., President of the American Medical Association and John Kernodle, M.D., Chairman, AMA Board of Trustees. In addressing the delegates Dr. Hoffman spoke on unionism. He questioned why any physician would choose to belong to a union, run by a labor group, rather than organized medical societies of physicians.

Exhibitors Win Scientific Awards

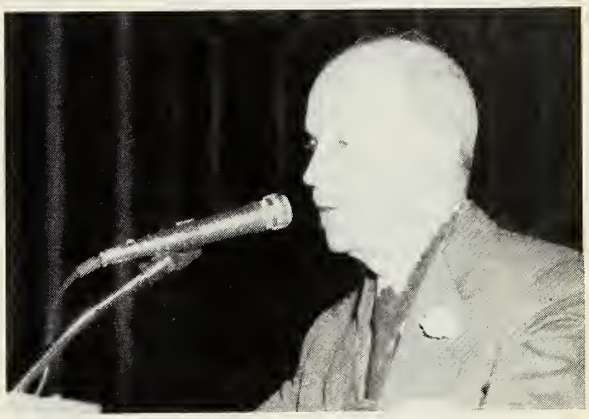
Eugene Tarde, M.D. presented the following with plaques for the best scientific exhibits at the convention;

First Prize—B. H. Gerald Rogers, M.D., Henrotin and Grant Hospitals, Chicago, for his display "Flexible Colonoscapty, a New Diagnostic and Theropeutic Technique.

Second Prize—Henry J. Heimlich, M.D., Director of Surgery at Jewish Hospital, Cincinnati, Ohio for his exhibit "Esopohagas Replacement with RGT (Revised Gastric Tube)."

Third Prize—Wm Wolff, M.D., Beth Israel Medical Center, New York, for his presentation of "Non-Operative Excision of Colonic Polyps."

Dr. Scrivner Launches "USE" Program



In his inaugual address, Willard C. Scrivner, M.D., newly installed ISMS President, proposed his program for the coming year based on the precepts of UNITY, STRENGTH and EFFECTIVENESS (USE).

Under Dr. Scrivner's "Program of Progress" he encouraged ISMS to assist communities in establishing local or area health departments. Dr. Scrivner especially emphasized ISMS helping to improve the health care of the poor and migrant workers and their families. Within this area of concern, Dr. Scrivner urged an intensive hypertension screening program among the Illinois black population.

Dr. Scrivner proposed establishment of an autonomous state medical disciplinary board which would investigate physicians suspected of misconduct or incompetency. He emphasized that this board would ACT, not just recommend. He also urged an ISMS survey of the members to determine involvement in continuing medical education during the last three years.

A public hearing on health was recommended by Dr. Scrivner. This hearing would give consumer organizations an opportunity to express health concerns and outline their suggested solutions to the problems that effect health care in Illinois.

To assure the success of this Program of Progress, Dr. Scrivner told the members of the assembly that it was in their hands to make it such.

Illinois Medical Schools Presented AMA-ERF Check



Frank J. Jirka, Jr., M.D., (left) ISMS President, presented the AMA-ERF check for $124,-122.15 to James E. Eckenhoff, M.D., Chairman, Council of Medical School Deans. In accepting the check, Dr. Eckenhoff noted that Illinois is the largest state exporter of physicians in the United States.

The amounts of money contributed by ISMS members for each medical school are as follows: Rush Medical College, $12,979; University of Chicago Pritzker School of Medicine $11,116; Northwestern University, $27,767; University of Illinois, $25,335. (These latter two are the largest awards in the U.S.)

Southern Illinois University, $6,273; Chicago Medical School, $14, 894; Stritch School of Medicine, Loyola, $21,165; Rockford Medical School, $3,298; and Peoria Medical School, $1,295.

Fifty-Year Club Hosts Luncheon

The Fifty-Year Club welcomed 81 new members at its 36th Annual Luncheon. Joseph H. Skom, M.D., First Vice-President of ISMS, presided at the luncheon. There is a total membership of over 600 and 124 were in attendance. Entertainment was provided by the American Association of Medical Assistants, who presented "Opus Offus Operatus No. 1."

Reference Committees Important To Annual Meeting

During the late hours of the first day of the annual meeting, nine reference committees met to review materials and decide on recommended action or policy in their respective resolutions. Each committee studied reports and resolutions which were introduced. Written recomendations to accept, reject or refer the actions were presented to the House. Serving as committee chairman were:

Officers and Administration	Roland Kowal, M.D.
Finances, Budgets & Publications	James McDonald, M.D.
Constitution and Bylaws	Howard Burkhead, M.D.
Economics, Peer Review, Social & Medical Services	Joseph Moles, M.D.
Governmental Affairs & Medical Legal	William Ackley, M.D.
Education & Manpower	Jerry Ingalls, M.D.
Environmental Community & Mental Health	John Hipskind, M.D.
Public Relations & Miscellaneous Business	E. T. Leonard, M.D.
Open Forum	John Hubbard, M.D.

Active Year for the ISMS Woman's Auxiliary



Mrs. August Martinucci

In the annual address of the Auxiliary president, Mrs. August (Livia) Martinucci told the House that the Woman's Auxiliary had completed a fruitful year. Areas of concern included legislation, nutrition, safety, health careers and membership. The WA/ISMS is proud to have three past-presidents serving at the national level: Mrs. Willard C. Scrivner, Mrs. Wendell Roller and Mrs. Sherman Arnold. Mrs. Martinucci praised the efforts of the ISMS Auxiliary to lead the nation in contributing funds for AMA-ERF.

Mrs. Hartman New WA/ISMS President

Mrs. Robert (Bea) Hartman, Jacksonville, was inaugurated as President of the Woman's Auxiliary to the Illinois State Medical Society during the annual convention of the Auxiliary. Mrs. Hartman was guest of honor at the luncheon which carried out her theme *Ad Astra Per Aspera* (To The Stars Through Your Aspirations).

Dr. Balthazar Is "Humanitarian of the Year"



Eugene R. Balthazar, M.D., (left) Aurora, received the first ISMS "Humanitarian of the Year Award." The presentation to Dr. Balthazar was the first official action by newly installed ISMS President, Willard C. Scrivner, at the closing session of the House of Delegates.

Upon retirement as a physician for 50 years, Dr. Balthazar established a "free" clinic for the poor of all races, creeds, and colors in a county that had few hospital or municipal clinics to provide medical care for the needy.

In accepting his Award the 71-year old physician stated that he enjoys what he is doing and considers it a personal and professional obligation to the people of Aurora who have been good to him for so long, and to his own profession which he respects so highly.

ISMS Medical Journalism Fellowships Awarded



Geri Reynolds, (left) Peoria, and Norma Roth, Rockford, were recipients of the Seventh ISMS Medical Journalism Fellowships. The presentations to the reporters were made by Lee F. Winkler, M.D., Chairman, Council on Public Relations, at the closing session of the House of Delegates. As guests of the state medical society during the annual meeting, the reporters acquired first-hand knowledge of the workings of the medical profession as physicians propose solutions to health care problems.

Public Affairs Breakfast Well Received

Over 300 ISMS members, spouses and Woman's Auxiliary members gathered for a Public Affairs Champagne Breakfast held during the annual meeting. John Tower, U.S. Senator from Texas was guest speaker. Other invited guests included Congressmen Robert P. Hanrahan, Edwin Madigan, George O'Brien and Sam Young. The Public Affairs Brunch was a new attraction; in the past a Public Affairs Dinner had been held.

Leslie Arey Receives Education Award



The 1973 Edwin S. Hamilton Interstate Teaching Award was awarded to Leslie B. Arey, Ph.D., (left) eminent scientist and professor of anatomy emeritus at Northwestern University. Mather Pfeiffenberg, M.D., ISMS Trustee and Trustee, Interstate Post Graduate Medical Association of North America, presented the plaque and honorarium of $500.00 to Dr. Arey. This award is sponsored by IPMANA, and the ISMS Council on Education and Manpower selects the annual winner from nominations made to it.

Dr. Arey has "volunteered 17 full-time years" past his retirement to textbooks on histology and embryology. The 82-year-old professor currently serves on the editorial boards of *Dorland's American Medical Dictionary* and "Excerpta Medica" and is a contributor to *Encyclopedia Britannica.* In addition, he is producer of the Eaton Company Medical Film Series and lecturer at Northwestern University Medical School and Dental School, and Illinois College of Podiatry.

For the past seven years the Edwin S. Hamilton Award has been presented in honor of the Kankakee physician and former ISMS president in recognition of his years of service to the postgraduate group.

Medical Assistants Ask for Continued Support



Mrs. June Hall, President, Illinois Society, American Association of Medical Assistants, gave her annual report at the opening session. She reported a total of 27 active chapters representing 34 Illinois counties. Throughout the year the society held numerous workshops and provided educational traveling courses. Subjects covered during the year included emergency care, Medicare, office courtesy and telephone etiquette. Mrs. Hall encouraged county medical societies to acquaint themselves with the medical assistants. She thanked ISMS members for their support and asked for their continued support of the medical assistants and their society.

IMPAC Had a Strong Year

V.P. Siegel, M.D., Chairman of the Illinois Medical Political Action Committee (IMPAC) told the House of Delegates that 86% of the legislative candidates supported by IMPAC were victorious in last November's election. A total of 111 candidates won and 17 lost their bid to a political office. IMPAC has had a strong showing and he encouraged greater participation and support.

ISMS Executive Administrator Urges Better Communication

Roger N. White, ISMS Executive Administrator, in his annual report, noted that communication to the members is of top concern. He felt that the newest publication "Action Report" was a positive way of reaching the membership to inform them of activities. Mr. White encouraged the delegates to help ISMS reach the membership and to let the ISMS office know what it can do to help.

Illinois HASP Program Ahead of Other States

"The HASP Program in Illinois is one year ahead of other states," reported Joseph R. O'Donnell, M.D., President of the Illinois Foundation for Medical Care and ISMS Trustee. IFMC now has a membership of 2,500 and the membership is one of the largest in the U.S. Dr. O'Donnell reminded the ISMS members that membership in the Foundation is "free." Foundation activities are becoming more and more important in the socio-economics of health care delivery, with the HMO, PSRO, and other systems. The delegates were told the imperity of being involved with and knowledgeable about Foundation interests.

New AMA Delegates Elected

Illinois gained one additional seat to the American Medical Association as a result of membership increase. A total of 12 physicians will represent ISMS at the AMA House of Delegates:

Charles K. Wells, M.D., was elected to serve the unexpired term of Joseph Mallory, M.D. Dr. Wells will begin his term immediately and it expires in 1974. Frank J. Jirka, Jr., M.D., will fill Harold A. Sofield's position beginning January 1, 1974.

William M. Lees, M.D. will fill the additional delegate seat that is effective immediately and expires in 1975.

Other delegates elected to serve from January 1, 1974 until December 31, 1975 are:

Jack Gibbs, M.D.; Theodore Grevas, M.D.; Morgan Meyer, M.D.; Edward Piszczek, M.D.; and Philip Thomsen, M.D.

Joseph O'Donnell, M.D. was elected to fill the additional alternate position. His term begins immediately and ends December 31, 1975.

Allison Burdick, Jr., M.D. fills Dr. Lee's alternate vacancy and Jerry Ingalls assumes the unexpired term of Dr. Wells. Both new alternates' terms begin immediately and expire December 31, 1975.

Fredric Lake will assume an alternate position in 1974 to fill Dr. Jirka's unexpired term.

Other alternate delegates elected to serve from January 1, 1974 until December 31, 1975 are:

Herschel Browns, M.D.; George Shropshear, M.D.; Paul Sunderland, M.D. and Glen Tomlinson, M.D.

PSRO Plan to be Implemented in Illinois

Before the annual meeting, a group of concerned physicians gathered to discuss Professional Standards Review Organization (PSRO). Principal speakers at the PSRO Conference included John R. Kernodle, M.D., Chairman of the American Medical Association's Board of Trustees; William M. Lees, M.D. ISMS Board of Trustees Chairman, and Joseph R. O'Donnell, M.D., President of the Illinois Foundation for Medical Care.

During the conference, the ISMS Board of Trustees was directed to implement a "unified PSRO plan for Illinois under conditions favorable to the physicians." Before implementing

the new plan, ISMS will discuss the proposal with the county societies.

No Change in Dues

The House of Delegates voted to maintain the present dues for membership. A breakdown of the allotments is:

ISMS Dues	$105.00
AMA-ERF	10.00
ICCME	10.00
Benevolence Fund	5.00
Spec. Liasion To Students and Physicians in Training	1.00
	$131.00
IMPAC (voluntary)	45.00*
	$176.00

**$25.00 for a single membership and $20.00 for spouse.*

Continuing Education Criteria For Re-Registration

Continuing medical education as the criteria for re-registration for Illinois physicians was passed by the House of Delegates. Under this resolution, ISMS was given the primary role in certifying the educational quality of the continuing medical education programs and to see that this action does not decrease the availability of physicians in communities to an extent that adequate medical care is jeopardized. The Council on Education and Manpower is to develop an appropriate mechanism for accreditation of CME programs through ICCME.

ISMS Delegates Serve For the First Time



Serving as members of the ISMS House of Delegates for the first time were: (from left to right, front row) William B. Frymark, M.D., Hinsdale; Charles G. White, M.D., Naperville; Paul P. Lorenz, Carbondale; Loren M. Boon, M.D., Danvers and A. Beaumont Johnson, Elgin.

Second row: Alfred J. Kiessel, M.D., Decatur; John Seward, M.D., Rockford; Elliott O. Partridge, M.D., Eldorado; Michael J. Hughey, SAMA and Larry Plummer, M.D., Jerseyville.

Back row: Paul Sunderland, M.D., Speaker of the House.

ISMS Proposes Preamble Change for Hospitals

After much deliberation, the House of Delegates passed a preamble change to be in the constitution of the Illinois hospitals. This action came about due to the recent unilateral changes in medical staff by-laws by hospital boards of trustees. The preamble reads:

"The practice of medicine is the physician's legal prerogative and responsibility. The quality of medical care in a hospital should be maintained and supervised by and through its medical staff; in helping to insure the quality of medical care, each hospital has the duty to cooperate with and assist its medical staff in developing procedures to accomplish this end."

Other Actions Taken by the House . . .

1. ISMS was directed to seek legislation requiring insurance carriers to provide coverage of consultant and assistant surgeon's fees "when documentation of their medical necessity is available;

2. Removal of all taxes on drugs was encouraged,

3. AMA is to be urged to develop a health care training program for migrant workers.

1973-1974 Officers Elected

At the close of the annual meeting the following physicians were elected to serve as officers and trustees during 1973-1974:

President-Elect	Fredic Lake
First Vice President	Paul H. Sunderland
Second Vice President	Charles Weigel
Secretary-Treasurer	Jacob E. Reisch
Speaker of the House	Andrew J. Brislen
Vice Speaker of the House	James A. McDonald

Trustees

David Fox	Third District
Robert Fox	Third District
Fred Weiss	Third District
Joseph Skom	Third District
Fred Z. White	Fourth District
Edward A. Livingston	Fifth District
Arthur Goodyear	Seventh District
Eugene Johnson	Ninth District

Summary of Actions of the 1973 House of Delegates

I. AMENDMENTS TO CONSTITUTION AND BYLAWS

In accordance with constitutional provisions, the 1973 House of Delegates adopted a resolution presented a year ago to amend the society's constitution by arranging its articles in an order considered more logical than the original. The House also amended the bylaws to:

A. Allow physicians moving out of state to retain ISMS membership rights up to one year until they are accepted into the medical society of the state to which they have moved.

B. Deny retired status to physicians who assume compensated positions after retiring from medical practice.

C. Reduce to two years the number of years the Speaker and Vice Speaker may serve in their respective offices.

D. Provide for the Second Vice President to become First Vice President in the event that a vacancy occurs in the latter office.

E. Provide for the Vice Speaker of the House of Delegates, the First Vice President and the Second Vice President to become voting members of the Board of Trustees.

F. Establish a Council on Affiliate Societies to be concerned in the areas of liaison between the affiliate society and ISMS, scientific resource information and advice to ISMS, consultation to other councils, and advances of medical science in special fields. The council will be made up of one representative of each recognized specialty society in Illinois.

G. Establish annual appointments to ISMS councils and committees and to limit the tenure to five consecutive terms for members.

H. Include the First Vice President as a member of the Executive Committee.

I. Require each county medical society to forward to the ISMS Secretary its roster of officers and members and a list of its delegates and alternates no later than 120 days prior to the annual meeting.

J. Require the use of Sturgis Standard Code of Parliamentary Procedure as a guide for conduct of all ISMS meetings.

In addition, the Committee on Constitution and Bylaws was directed to study the feasibility of establishing a classification for non-resident members and to re-evaluate the qualifications for emeritus members as specified in the current bylaws. It was suggested that emeritus status be available to physicians at age 65 (now 70) and after 30 years of membership rather than the present 35 years.

II. REPORTS OF OFFICERS AND ADMINISTRATION

The House referred to the Board of Trustees' Committee on Redistricting and Tenure a proposal to make the present First Trustee District correspond with Region 1-A used by Comprehensive Health Planning and other agencies. This would mean removing Kane, McHenry and Lake counties from the First District and adding Lee and Whiteside counties. The proposal will be considered by the Redistricting Committee, which has not made any recommendations yet because of the complexity of its assignment. In a report to the House, however, this committee suggested five possibilities for redistricting the state:

A According to legislative districts.
B. According to medical service areas.
C. A modification of the state's CHP districting.
D. A modification of the ISMS district plan.
E. According to "Home Rule Principles," that is, reassigning county medical societies only upon the request of the individual counties in view of their own changing needs and health care patterns.

The House also approved a proposal that ISMS build, purchase or lease suitable office facilities with the future needs of the society in mind. It was pointed out that the lease of present office space at 360 N. Michigan Ave., Chicago, expires in 1975.

III. FINANCES, BUDGETS AND PUBLICATIONS

The House approved a 1973 operating budget of $1,028,325 based on the following dues structure:

Operating Fund	$105
AMA-ERF	10
Illinois Council on Continuing Medical Education	10
Benevolence	5
	$130
Special Assessment for liaison with students, interns and residents	1
	$131
IMPAC-AMPAC Family Membership (Voluntary)	45
	$176

With the increase in dues becoming effective this year, a five year budget projection reflects a balanced budget through 1977. The deficit as of December 31, 1972, is removed in 1973. Funds are allocated to the Permanent Reserve Fund in the years 1973-1975. Funds allocated to the Contingency Reserve Fund in 1973-1975 will be used in 1976 and 1977 to maintain a balanced budget as expenses increase and the operating fund goes into negative net funds available.

The above dues breakdown includes three separate House actions:

Continued start-up funding for the Illinois Council on Continuing Medical Education, continued funding for liaison with students, interns and residents, and authorization to qualify ISMS and its Woman's Auxiliary as an AMA-ERF total project credit contributor.

IV. ECONOMICS, PEER REVIEW, SOCIAL AND MEDICAL SERVICES

The economic aspects of medical practice were treated by a series of measures relating to physician fees and billing for services.

A proposal was adopted that the Illinois Department of Public Aid purchase for each recipient a comprehensive health care policy which provides for the broadest type of in-patient and out-patient health care benefits, including preventive maintenance, check-ups, immunizations, etc. Also, that a cash grant be provided to all recipients in an amount calculated to meet the co-payment and deductible cost which will be required at the time service is rendered. It was pointed out that federal law prohibits implementation of the plan at this time, but the AMA will be asked to seek appropriate legislation that would permit it.

The House also ordered that:

A. The AMA be requested to encourage physician to educate patients regarding their responsibility to physicians for payment of fees. In addition, the AMA be requested to promote the general use of the Statement of Understanding developed by ISMS in response to the failure of third party payors to pay usual, customary and reasonable fees.

B. ISMS and/or the Illinois Foundation for Medical Care develop model health insurance policies that are realistic and reasonable. Such model plans are to be made available to component medical societies, carriers, patients, governmental agencies and to the public in order that they be informed as to what an adequate health insurance policy should be.

C. ISMS inform all insurance carriers that fee information is to be released to state or component society peer review committees upon request. The Board of Trustees should take any steps necessary to insure cooperation.

D. ISMS take a strong position supporting coverage of assistant surgeon's fees and consultant's fees in all health insurance policies. Legislation should be sought by ISMS that makes it mandatory for all commercial health insurers to provide coverage for these fees where there is documentation of their medical necessity.

E. When a county medical society is unable or unwilling to enter into meaningful participation in areawide health program planning, this function shall be assumed by the appropriate district committee of ISMS.

F. ISMS petition the Department of HEW to add to the Medicare claim form the statement, "I wish payment for this claim to be made directly to my physician," and to allow such payment to be made when requested by the patient. Support of the Illinois Congressional delegation will be sought for this change in the Medicare payment procedure

G. An appropriate committee of ISMS confer with HEW and Medicare carriers to rectify the arbitrary disallowance of claims and to clarify the role of diag-

nostic procedures and tests in the providing of good quality medical care.

H. The Board of Trustees proceed with a revision of the Illinois Relative Value Study and the study be sold to interested parties, if necessary, to defray the cost. As part of this resolution, the House reaffirmed its policy that the basis of all fee payments should continue to be the usual, customary and reasonable concept.

J. The Board of Trustees, working with appropriate councils, seek to obtain amendments to the Emergency Medical Service Act to improve the delivery of emergency care in Illinois.

K. The following policies be adopted for providing nursing home patients with adequate medical service:
 1. That every nursing home patient have an active attending physician or alternate who acknowledges his continuing responsibility in writing.
 2. That if the attending physician does not exercise his responsibilities, the local medical society be urged to assist nursing homes by supplying the names of physicians who will agree to provide such medical coverage.
 3. That patients or responsible family members be urged to select a physician of their choice or be fully consulted prior to the undertaking by nursing home of any other arrangements.
 4. That inequitable and self-defeating Public Aid policies on reimbursement of physicians serving nursing homes be corrected.

L. ISMS reaffirm its complete support of the AMA Principles of Medical Ethics, including the statement that "In order to conform to the ethics of the American Medical Association, three requirements must be satisfied in connection with the use of experimental drugs or procedures:
 1. The voluntary consent of the person on whom the experiment is to be performed should be obtained.
 2. The danger of each experiment must be previously investigated by animal experimentation.
 3. The experiment must be performed under proper medical protection and management.

M. Medicredit be endorsed and these basic concepts be considered in any national health insurance:
 1. Individuals should have insurance protection available underwritten by risk-bearing insurance companies, providing comprehensive basic health protection and also including protection against catastrophic costs of illness.
 2. The pluralistic means of health care delivery should be afforded, with the individual having the freedom of receiving care from qualified providers of his choice.
 3. Any federal funding should be provided through general revenues, with government subsidy or assistance related to the individual's ability to pay.
 4. Cost sharing by the beneficiary, while fostering individual responsibility, should be reasonable and not act to prevent access to health care.
 5. Insurance policies or plans should be qualified by appropriate governmental regulatory bodies.

N. The Board of Trustees be authorized to undertake the necessary inquiring studies or other steps to create a unified PSRO plan for Illinois, and, that after appropriate communication and dialogue is held with component county societies, the Board be authorized to implement such a plan.

The House rejected a proposal to have the Illinois Foundation for Medical Care terminate its Hospital Admission and Surveillance Program and to have ISMS oppose any new health care delivery systems until physicians are adequately compensated by a consistent fee schedule under the various state services now existing. The latter proposal was considered incompatible with present ISMS policies. For the same reason, the House denied support for local option on fee reimbursement.

Two proposals were referred to the Council on Economics and Peer Review. The first was a request that billing for Medicaid and Medicare be combined. It was generally agreed that this would be impossible to implement, but the council was requested to study the idea. The council also will study the possibility of developing agreements with insurance carriers on the filing of claims and payment of fees if negotiations now under way with the AMA, the Health Insurance Council and Blue Shield appear to

be unfruitful.

V. EDUCATION AND MANPOWER

In addition to providing additional funding for the Illinois Council on Continuing Medical Education, the House adopted three measures dealing with accreditation of continuing education courses and support of the council.

A. It endorsed the concept of continuing education as the condition for re-registration of physicians, provided that ISMS has the primary role in certifying the educational quality of the continuing education programs and that the action does not decrease the avaliability of physicians in communities to an extent that adequate medical care is jeopardized.

B. It authorized action encouraging hospital medical staffs and other organizations to develop learning activities as formal courses to be accredited through the Council on Education and Manpower and urged physicians to participate in self-assessment test programs prior to registration in hospital courses and other learning activities.

C. It directed the Board of Trustees to consider appointing a house staff representative to the Illinois Council on Continuing Medical Education.

Rejected was a proposal to have ISMS oppose residency training programs in allergy as prescribed by the AMA Council on Medical Education. Those opposed to the training programs claim they were set up by a board not fully representing all physicians practicing in allergy.

VI. ENVIRONMENTAL, COMMUNITY AND MENTAL HEALTH

In an effort to help the Illinois Department of Mental Health upgrade its services and facilities, the House approved the recommendations of a special liaison committee which has been meeting with IDMH representatives

ISMS urges each constituent county society and branch of the Chicago Medical Society to cooperate fully with and support local units of the Department of Mental Health in its patient care efforts, specifically seeking to encourage:

A. Local general hospitals to accept mental health patients who can be helped by short-term treatment, leaving to state institutions responsibility for such chronic and long-term cases which local hospitals cannot presently handle.

B. Local hospitals and practitioners to retain in their own care those geriatric patients who have ailments of primarily physical nature.

C. Local physicians, local hospitals and local skilled nursing facilities to provide primary and secondary care for psychiatric problems to the extent possible, given facilities and physician-time available.

D. Arrangements for emergency mental health care, i.e., crisis intervention, to be provided in each locality.

E. To the extent needed, local physicians and other health care personnel to be properly trained and local hospitals to be aided in order to enable them to provide primary and secondary mental health care.

These guidelines include the provision that all physician and other health service provided under such arrangements would be on the same fee-for-service basis as would other medical services, paid either by the patient or third party insurers.

The House also approved the concept of implementing the recommendations contained in the Getting Report of the Illinois Department of Public Health, establishing liaison between the Council on Environmental and Community Health and IDPH to develop regionalization of public health activities in Illinois.

ISMS will urge the AMA, through its Committee on the Health Care of the Poor, to establish special training programs for health care volunteers who are members of migrant families. This will allow these volunteers to function as health advocates for all migrants, offer temporary care as needed, direct families to existing medical facilities, interpret the needs of the people to the medical community, and to extend prescribed care to families as they move.

Facing its obligation to provide Illinois physicians with guidelines for performing abortions under law while eliminating moral and ethical considerations, the House adopted the following policies for the protection of the citizens of Illinois:

A. The decision by either physician or medical facility to accept a patient for abortion shall be entirely voluntary.

B. All abortions, for whatever cause, shall be performed only by physicians licensed to practice medicine in all of its branches, and shall only be performed pursuant to the execution of an appropriate consent form.

C. A 48-hour period should elapse from the time of mutual consent between patient and physician to perform voluntary abortion until the abortion is actually undertaken; the elapse of this 48-hour period shall be acknowledged in writing by the patient prior to the abortion itself.

D. All abortions shall be performed in an appropriate setting.

E. All abortions performed after the 12th week (Nagele's Rule) shall be done in a hospital providing adequate clinical laboratory facilities and licensed by the Illinois Department of Public Health; such patients should be observed for 24 or more hours post-operatively.

F. Periodic statistical reports, including incidents of morbidity, on all abortions at whatever stage shall be forwarded to the Illinois Department of Public Health.

G. If not in conflict with state and federal law, no abortion so performed will be considered unethical

VII. PUBLIC RELATIONS, MEMBERSHIP AND MISCELLANEOUS BUSINESS

In an attempt to promote wider membership in IMPAC, the House ordered a revision in dues bills to indicate a $45 family contribution to IMPAC-AMPAC. This voluntary contribution has been shown as $25 for the physician and the spouse's $20 contribution has been paid separately.

VIII. GOVERNMENTAL AFFAIRS AND MEDICAL-LEGAL

The House took the following action on legislative proposals:

A. Approved the seeking of legislative action to modify the system of narcotic regulation numbers. The present system is considered cumbersome and inconvenient for use by practicing physcians.

B. Referred to the Governmental Affairs Council the question of modifying the Physical Therapy Act to insure that amendments being proposed by the Department of Registration and Education are in accord with ISMS policy.

C. Called for removal of the state tax on drugs sold in Illinois.

D. Affirmed the policy that in questions of medical treatment of minors where parental consent is not legally required, the physician's judgment shall prevail on whether or not the parents should be informed of such treatment.

E. Endorsed a policy statement affirming that "The practice of medicine is the physician's legal prerogative and responsibility. The quality of medical care in a hospital should be maintained and supervised through its medical staff; in helping to insure the quality of medical care, each hospital has the duty to cooperate with and assist its medical staff in developing procedures to accomplish this end." The statement was developed to support medical staffs in opposing unilateral changes in medical staff bylaws by hospital boards of trustees.

F. Indicated complete support for the vigorous position of the AMA in opposing Rule 504 of the proposed Federal Rules of Evidence. The new rule would eliminate the guarantee of physician-patient confidentiality.

IX. OPEN FORUM

The first ISMS attempt to provide an open forum for any member to bring his individual problems, suggestions or complaints before the House of Delegates resulted in specific recommendations. Physicians participating in the open forum suggested that ISMS establish ongoing liaison with all hospital medical staffs and maintain a data bank of ideas for medical staffs in dealing with hospital boards and administrators. They also expressed concern over increasing use of alcohol, urging the profession to exercise leadership to combat alcoholism, as exhibited in combatting drug abuse and cigarettes. ◄

Actions on Resolutions
1973 House of Delegates

Number	*Introduced By:*	*Subject*	*Action*
73M-1	William M. Lees	Continued Start-up Funding for ICCME	Adopted
73M-2	John Ovitz	Cooperation with Local Units of IDMH	Adopted as amended
73M-3	C. J. Jannings	Health Care Insurance and Cash Grants for Public Aid Recipients	Adopted
73M-4	Fredric Lake	Amendments to By-Laws	Adopted
73M-5	Jack L. Gibbs	Continuing Medical Education	Substitute adopted
73M-6	E. K. DuVivier	Combined Billing and Payment	Referred to Council on Econ. & Peer Review
73M-7	George Wilkins	IMPAC/AMPAC Family Membership	Adopted
73M-8	Morgan Meyer	Use of Statement of Understanding	Adopted
73M-9	Morgan Meyer	Model Health Insurance Plan	Substitute adopted as amended
73M-10	John S. Hyde	Response to 72M-20 Getting Report	Adopted as amended
73M-11	Fred A. Tworoger	Release of Fee Profiles from Third Parties	Adopted
73M-12	Fred A. Tworoger	Payment for Ass't. Surgeon's Services	Substitute adopted as amended
73M-13	James A. McDonald	Areawide Health Services Planning	Adopted as amended
73M-14	James A. McDonald	Local Option in Selecting Fee Reimbursement Method	Rejected
73M-15	Wayne Leimbach	Physician's Federal Narcotic Numbers	Adopted
73M-16	Frank J. Jirka	Medicare Payment Procedures	Adopted
73M-17	Fred Z. White	Health Care of Migrant Workers	Adopted
73M-18	Julian Buser	Filing of Insurance Claim Form	Referred to Council on Econ. & Peer Review
73M-19	E. T. Leonard	Establishment of 1-A Trustee District	Referred to Board of Trustees' Committee on Redistricting
73M-20	Julian Buser	Medicare Procedures	Substitute adopted

Number	*Introduced By:*	*Subject*	*Action*
73M-21	A. Beaumont Johnson	Disapproval of HASP	Rejected
73M-22	Theodore Grevas	Resolution to Revise the Illinois Relative Value Study	Substitute adopted as amended
73M-23	Jack Gibbs	Accreditation of CME	Substitute adopted as amended
73M-24	W. O. Ackley	New ISMS offices	Adopted as amended
73M-25	Robert Hartman	Abortion Guidelines	Substitute adopted as amended
73M-26	James Sutherland	Physical Therapy Act	Referred to Governmental Affairs Council
73M-27	Kermit Mehlinger	Erection of Parking Facility at Cook County Hospital	Too late to be considered
73M-28	Kermit Mehlinger	Discontinuation of all Tax on Food and Medicine	Substitute adopted
73M-29	Kermit Mehlinger	Physical and Mental Dangers of Alcohol Abuse	Too late to be considered
73M-30	Jack Gibbs	Amending Emergency Medical Service Act	Substitute adopted
73M-31	Mack Hollowell	Residency Training in Allergy	Rejected
73M-32	C. P. Cunningham	Nursing Homes	Adopted as amended
73M-33	Michael Hughey	Continued Funding for Liaison with Students, Interns and Residents	Adopted as amended
73M-34	Michael Hughey	ICCME	Substitute adopted
73M-35	John Ring	AMA/ERF Contributions	Substitute adopted
73M-36	Joseph Bordenave	Experimental Medical Procedures in Relation to Medical Ethics	Adopted
73M-37	Alfred Klinger	Nutrition Centers	Too late to be considered
73M-38	Alfred Klinger	Ongoing Nutritional Survey	Too late to be considered
73M-39	Joseph Bordenave	Unilateral Changes in Medical Staff ByLaws by Hospital Board of Trustees	Withdrawn
73M-40	George Shimkus and Joseph Bordenave	Medical Treatment of Minors without Parental Consent	Substitute adopted
73M-41	Loren Boone	Fee Schedule for Reimbursement under Grant Health Programs	Rejected
73M-42	Joseph Bordenave	Support of Medical Staffs	Adopted as amended
73M-43	William M. Lees	Medicredit	Adopted
73M-44	William M. Lees	PSRO	Adopted
73M-45	William M. Lees	Privileged Communications	Adopted ◄

Doctor's News

ISMS ENDORSES ABORTION RESTRICTIONS—ISMS has endorsed support for three legislative bills which establish medical guidelines for abortion and to license and regulate ambulatory surgical treatment centers. These were developed between ISMS, IDPH and IHA. At a news conference in Chicago, Joyce Lashof, M.D., Acting Director of the Illinois Department of Public Health, explained the bills sponsored by State Senator Don Wooten, Rock Island.

The Illinois Abortion Law seeks to protect physicians who decline to perform an abortion from civil or criminal liability. In addition, the bill requires that abortions be performed only by physicians licensed to practice medicine in all its branches; all abortions performed during the second trimester are to be done in a hospital only, abortions during the third trimester must be performed for therapeutic reasons following consultation with two other physicians and all abortions are to be reported to the IDPH for statistical purposes.

The amendment to the Medical Practice Act would restrict performance of abortions to licensed hospital or ambulatory surgical treatment centers licensed and supervised by the state.

The Ambulatory Surgical Treatment Center Act defines such a center as a facility devoted primarily to medical and surgical procedures. The IDPH, with assistance of an advisory board, will license and regulate these centers.

PSRO PILOT PROGRAM DISCUSSED—The development of an Illinois PSRO pilot program involving Medicare recipients is being explored by ISMS and the Illinois Foundation for Medical Care. Representatives from ISMS and IFMC met recently with Social Security Administration officials to discuss the PSRO program.

PHYSICIANS DELINQUENT TO SIGN BIRTH CERTIFICATES—The Illinois State Registrar of Vital Records reminds physicians that delinquency to sign birth certificates within the required 24 hour limit causes tardy registrations. Delays in the registrations make it impossible for families to promptly procure certified copies for benefits and creates numerous administrative problems.

SOUTHERN COUNTIES TO BE SURVEYED FOR HEALTH MANPOWER NEEDS—Southern Illinois University's School of Medicine will survey 51 counties in central and southern Illinois to determine medical manpower and practice needs. The survey, conducted by the Departments of Surgery and Health Care Planning, will provide information for designing the medical curriculum and establishing residency programs to meet the next decade's health manpower requirements.

COMPETITION OPEN FOR OUTSTANDING RESEARCH WORK—The Institute of Medicine of Chicago is offering two cash awards of $750.00 each. The Dr. and Mrs. Elven J. Berkheiser Prize is offered for the best thesis for original research work in the field of orthopaedic surgery completed in 1973. The Joseph A. Capps Prize recognizes the most meritorious research in medicine or in the specialties of medicine completed in 1973. For detailed information contact the Institute of Medicine of Chicago, 332 S. Michigan Ave., Chicago 60604.

ARGONNE CANCER RESEARCH HOSPITAL RENAMED—The Franklin McLean Memorial Research Institute is the new name of the Argonne Cancer Research Hospital. The institute is operated by the University of Chicago under a contract by the U.S. Atomic Energy Commission.

PATIENTS SOUGHT FOR STUDY OF NEPHROTIC SYNDROME—"National Cooperative Study of Nephrotic Syndrome in Adults" is seeking patients, ages 16 to 65, with idiopathic nephrotic syndrome. This is a long-term double-blind controlled study to evaluate the effects of drugs on the natural history of the disease. The initial evaluation, the drugs, and subsequent follow-up will be provided to patients free of charge. For information, contact Jadwiga Roguska, M.D., Coordinating Physician of the project, Assistant Professor of Internal Medicine, Northwestern Memorial Hospital, Chicago 60611, or phone 312-649-3000.

PHYSICIANS IN THE NEWS—**Robert G. Barreck, M.D.,** has been elected President of the Augustanna Hospital Medical Staff, Chicago. **Charles A. Norberg, M.D.,** is the new Chairman of the Department of Surgery at Augustanna Hospital.

Frank J. Jirka, Jr., M.D., immediate Past-President of ISMS, has been re-elected as Chairman of the HASP Committee for the state. Other physicians appointed to the committee include: **Eugene Johnson, M.D.,** Casey; **Fred Tworoger, M.D.,** Chicago and **Fred Z. White, M.D.,** Chillicothe.

Frederick K. Merkel, M.D., has been appointed Director of the Transplantation Section at Rush-Presbyterian St. Luke's Medical Center.

Burgess L. Gordon, M.D., Chicago, was awarded a Special Recognition Award by the American Society of Internal Medicine. As director of the American Medical Association's Office of Current Medical Terminology, Dr. Gordon has devoted almost 20 years to the development of a universal nomenclature and coding system for the medical profession.

George H. Burke, Jr., M.D., Rock Island and **Raymond L. DelFava, M.D.,** Evanston recently were named as Fellows of the American College of Radiology.

Martin G. Durkin, M.D., Glen Ellyn, has been named as Associate Professor of Medicine and Chief of the Gastroenterology Section of the Loyola University Stritch School of Medicine.

Jose R. Napoles, M.D., has been selected as Director of the Uptown Family Health Center, Chicago.



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Abstracts of the Board

(Continued from page 412)

Use of Expense Voucher

ISMS officers, council and committee members, staff, etc., will be directed to pay hotel bills directly and seek ISMS reimbursement through expense vouchers rather than sign the bills on checking out. The new practice is designed to reduce bookkeeping problems.

Resolutions

The Board voted to initiate resolutions in support of Medicredit, a unified PSRO plan for Illinois, and privileged communications between physician and patient, and endorsed the abortion guidelines drafted by the Maternal Welfare Committee for presentation to the House of Delegates in resolution form.

The Board also approved the Finance Committee's recommendation on dues and authorized the following to be presented to the House:

Legislation Recommended

The Board agreed that if HMO legislation appears imminent, ISMS should support legislation creating short-term, experimental facilities rather than organizations of a broader scope. The Board's attitude will be communicated to the AMA and the Illinois Congressional delegation.

The Board also authorized support for: HB-177, which would require prompt payment by the state for goods and services and provide penalties for late payment; HB-29 which makes explicit the confidentiality of patient records; HB-144, which would include all mental hospitals in the legal definition of a hospital, and SB-111, which would limit the use of Mental Health Fund activities to other than capital construction.

As recommended by the Medical-Legal Council, the Board agreed to support SB-110, which extends for three years the waiver of liability for blood used in transfusions.

While the Board approved the general provisions of HB-366 and 367—which would create a state medical disciplinary board—it directed the Governmental Affairs Council to seek the following amendments to the proposed legislation:

1. Members of the disciplinary board should be elected by their peers rather than be appointed.
2. Chiropractors should not be included on the disciplinary board unless all chiropractors fall under the board's jurisdiction.
3. The disciplinary board should either have power to act itself or have its recommendations binding upon the Director of the Department of Registration and Education.
4. There should be provision for reinstatement of physicians who have been disciplined.
5. Board members should be compensated on a case basis rather than by an annual retainer.
6. Qualifications for board members should be specified.

If these amendments are not added, the Board believes ISMS should oppose the legislation.

It also agreed that ISMS should oppose HR-6, which calls for establishment of a legislative investigating commission on blood, and HB-74, which involves the right to die with dignity. It was pointed out that the latter subject should not be legislated.

On recommendation of the Council on Mental Health and Addiction, the Board reaffirmed its opposition to the separation of mental retardation functions from the Department of Mental Health and to proposed legislation for licensing marriage counselors. It also opposed HB-114, which would abolish the Mental Health Fund in Illinois.

IRMP Phaseout

At the request of Karl Dexter Nelson, M.D., Chairman of the IRMP Regional Advisory Group, the Board voted to support legislation providing use of some $275,000 in carry-over funds to accomplish an orderly phase out of regional medical programs in Illinois through February 14, 1974.

AMA Delegation to Meet with Executive Committee

The Illinois delegation to the American Medical Association will meet with the ISMS Executive Committee in May to review the handbook for the annual meeting of the AMA. Purpose of the meeting is to utilize the state level expertise in providing delegates with background information on resolutions on which they will be acting.

Nominate IFMC Board

The following have been nominated to the Board of Directors of the Illinois Foundation for Medical Care: Drs. Joseph Bordenave, Robert T. Fox, Allan Goslin, Frank J. Jirka, Jr., Eugene P. Johnson, William M. Lees, A. Edward Livingston, Joseph O'Donnell, W. C. Scrivner, Philip G. Thomsen and Frederick E. Weiss.

Council on Economics and Peer Review

By official action, the Board approved the following recommendations of the Council on Economics and Peer Review:

1. That local peer review committees charge a flat rate for adjudicating fee disputes, with the base rate being $25 per case, subject to adjustment by local committees depending on administrative costs.
2. That Blue Cross-Blue Shield not be censured for its Co-Care advertising because current marketing procedures and truth in advertising requirements make it necessary to list the individual facilities participating in the Co-Care program.
3. That ISMS recognize the HMO concept as another method of health care delivery. If HMO legislation is contemplated in Illinois, all appropriate state departments which may be involved in preparing this legislation—such as the Department of Insurance, Department of Public Health and the Comprehensive Health Planning Agency—should be informed that ISMS is ready and willing to work with them in the preparation of HMO legislation.

Council on Governmental Affairs

A council recommendation that ISMS leaders spend more time in Washington advancing the interest of Illinois medicine was approved in concept by the Board, which indicated it would "authorize an appropriate number of visits by designated people within our resources."

Approval also was given for a legislative workshop to be conducted for ISMS and Auxiliary members some time in May or June in Springfield.

Council on Education and Manpower

On recommendation of the Council on Education and Manpower, the Board released $8,000, the balance of ISMS' contribution to ASPIRA and the Council on Bio-Medical Careers. Last year a grant of $9,000 for each was authorized, with $5,000 being given immediately and $4,000 made contingent upon a site inspection to determine the scope of the programs and their efficiency. These visits were made by the Manpower Committee which recommended release of the additional funds.

Council on Mental Health and Addiction

The Board endorsed a council recommendation that reimbursement for mental health services under Medicaid be according to the usual, customary and reasonable fee concept and that any time unit system not be accepted except for service rendered which exceeds the usual time for a specific procedure.

Medical-Legal Council

ISMS will join the Chicago Medical Society, Illinois State Bar Association and Chicago Bar Association in forming a joint committee to establish a unified interprofessional code to apply to all attorneys and physicians in Illinois. ISMS members of the committee will be Drs. Donal O'Sullivan, David Petty and Herman Wing.

Joint Practice

By official action, the Board voted to rescind action taken at its January meeting regarding a statement prepared by the Joint Practice Committee. At that time, the Board agreed that there should be no change in the Medical and Nurse Practice Acts and that there should be moratorium on licensure of new groups of health care personnel. The statement is to be re-studied and a new report made to the Board.

Special Project Committee with IDMH

The Board approved the following recommendations of its special project committee on mental health and agreed to forward the suggestions to the Illinois Department of Mental Health (IDMH) and the Medical Examining Committee:

1. Request Medical Examining Comittee to make specific test results available to those who have failed so that these individuals can seek help needed to pass future tests.
2. Encourage IDMH to sponsor in-service continuing medical education courses for staff physicians and also attempt to establish mini-preceptorships for them with local physicians.
3. Request the IDMH to develop, in consultation with the Illinois Council on Continuing Medical Education, a one-day pre-test session for limited license physicians.
4. Suggest that the Department of Registration and Education and the Medical Examining Committee establish panels of medical school faculty physicians to interview permit doctors for identifying clinical competence.

The Board also approved these recommendations regarding the relationship between IDMH and the local medical community:

1. That there be identification of matching county medical societies and state mental hospitals; that the ISMS president write such county medical society presidents urging them to assist the superintendent of the local mental hospital in supervising his medical staff and offer help in accomplishing utilization and peer review and in developing an educational program.

2. That the Director of IDMH establish a small committee of hospital directors and ISMS representatives to identify problems and formulate suggested solutions on a continuing basis.

Committee on Emergency and Disaster Care

In view of the many unresolved questions and the concern expressed by ISMS members regarding areawide emergency medical planning, the Board declined an invitation to co-sponsor a public information-education seminar on the subject

to be conducted by the Department of Public Health April 24 in Springfield.

Insurance Committee

Recommendations of the Insurance Committee for implementing the new ISMS professional liability insurance program were referred to the Executive Committee for action. It was pointed out that the new program is based on peer review of applicants and claims and that specific guidelines and instructions will have to be provided committees responsible for making these judgments.

Student Loan Fund

By official action, the Board authorized the Student Loan Fund Board to accept a line of credit offered by the Country Life Insurance Co. to help stabilize the fund sponsored by ISMS and the Illinois Agricultural Association.

Re-elect Dr. Lees Chairman

In accordance with ISMS bylaws, the Board of Trustees met every day during the 1973 annual meeting. At its last session, Dr. William M. Lees was re-elected as Chairman of the Board. ◄

Obituaries

*__Alvis, Walter P.__, Benton, died March 6, at the age of 57. He was a former Chief of Staff at Evanston's St. Francis Hospital.

*__Bay, Emmett,__ died April 6 at the age of 75. He formerly was chief cardiologist at Billings Hospital, Chicago.

*__Becker, Leonard A.__, Elmhurst, died April 1, at the age of 59. He was a staff member at Elmhurst Memorial Hospital of Du Page County.

*__Blau, Alice,__ Chicago, died March 19, at the age of 59. She was a clinician at the Faith Bailey Health Center for 15 years.

**__Drolsom, George A.__, Chicago, died March 13, at the age of 84. He had practiced medicine for more than 50 years.

__Fox, Nathan M.,__ Chicago, died March 20 at the age of 79. He had offices in Chicago until his retirement three years ago, and was an associate professor of ophthalmology at the University of Illinois Medical School.

*__Johnson, Russell,__ Irving Park, died January 21.

**__Katz, Louis,__ died April 2, at the age of 75. He was a pioneer in developing ways to determine the presence of a form of hardening of the arteries. He was among the first to use and interpret electrocardiograms clinically. In 1930, he became a Director of the Cardiovascular Institute at Michael Reese Hospital, a position he held until he was named Director Emeritus in 1967.

He was President of the American Heart Association which gave him an Albert Lasker Award in 1956 and a Gold Heart Award in 1961.

*__Lang, Herbert,__ Armington, died March 9, at the age of 69. He had been Armington's only resident physician since 1936.

**__Lederer, Francis L.,__ Chicago, died April 3, at the age of 74. He was a noted specialist in eye, ear, nose and throat disorders. He had been with the University of Illinois Hospital for 45 years and was a former Chairman of its Otolaryngology Department. Dr. Lederer had served as President of the International College of Surgeons and the American Academy of Ophthalmology and Otolaryngology and Chief Associate Editor of the *Cyclopedia of Medicine.*

**__Miller, Paul Morton,__ Chicago, died March 12, at the age of 83. He had been a physician for more than 50 years.

*__Piper, Robert W.,__ White Hall, died February 25, at the age of 63. He was a graduate of Illinois College at Jacksonville, and from St. Louis University School of Medicine.

*__Sajewycz, Victor Charles,__ Matteson, died January 7 at the age of 57.

*__Schneider, Leo W.,__ St. Charles, died March 10, at the age of 65.

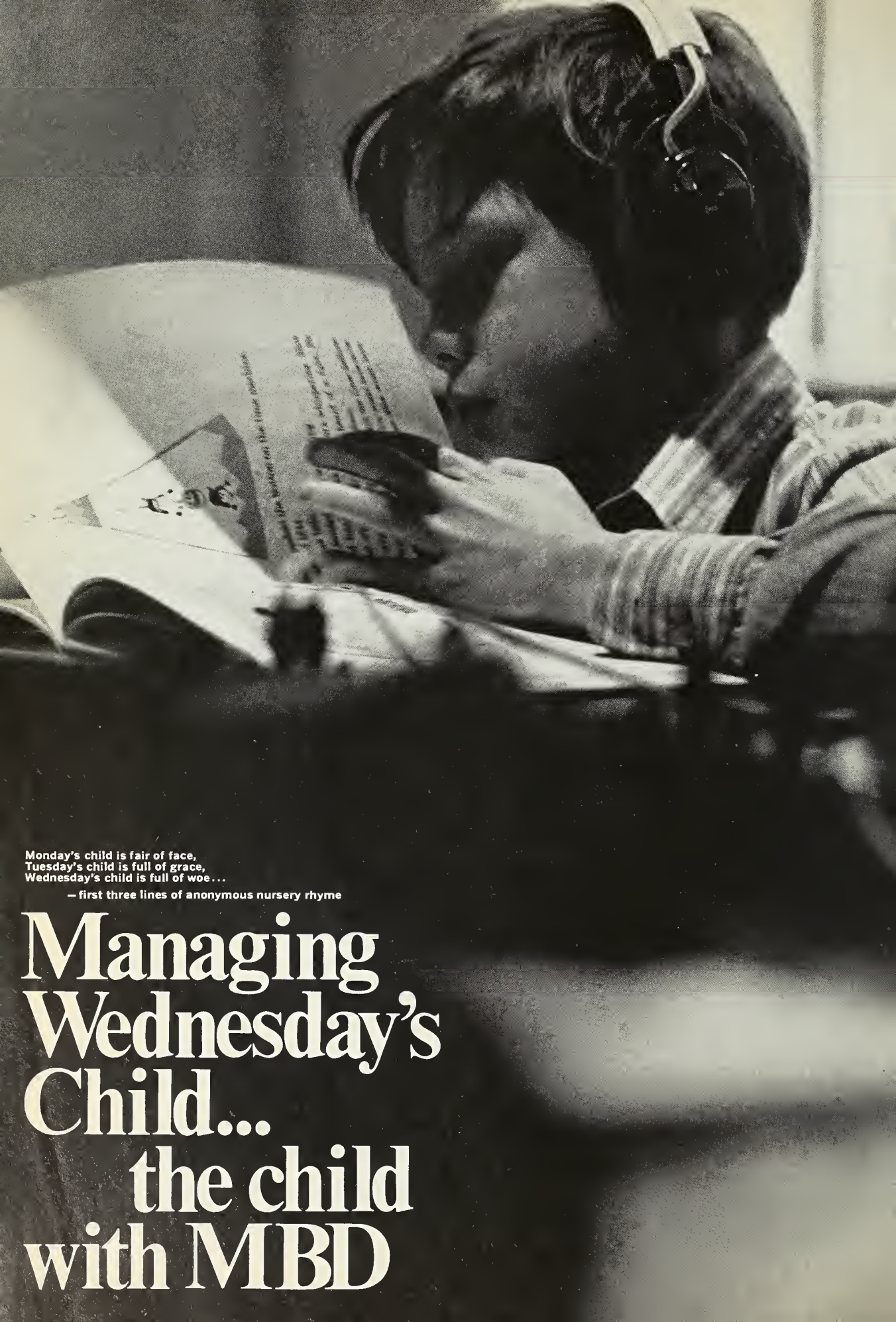
*__Smith, Charles Raimer,__ died at the age of 80. From 1925 to 1929, he was a pathologist and laboratory director at Decatur and Macon County Hospital. Dr. Smith gave the first blood transfusion by the citrate method in Decatur.

*__Sprenger, Lucille A.,__ Chillicothe, died at the age of 54. In 1961, she received a commemorative plaque from the St. Francis Hospital house staff.

*__Vynalek, William J.,__ died March 25, at the age of 72. He was a former Chief of Surgery and former Chief of the Medical Staff at MacNeal Memorial Hospital, Berwyn.

*__Wilsey, John D.,__ Chicago, died April 1.

**Denotes member of ISMS*
***Denotes member of 50-Year Club and ISMS*



Monday's child is fair of face,
Tuesday's child is full of grace,
Wednesday's child is full of woe...

—first three lines of anonymous nursery rhyme

Managing Wednesday's Child... the child with MBD

'ednesday's child is full of woe"
It need not be this way for the IBD child.
He can learn and adjust if given helping hand.

Without help, the MBD child may be a w reader, can find writing difficult, and thmetic hard to grasp. He may be excitable, d his actions can be disruptive. The result can riously hamper his educational and social velopment.

But, properly diagnosed and treated, MBD Minimal Brain Dysfunction—can be brought der control so that the afflicted child can velop normally.

And Ritalin can play an important part in e total rehabilitation program the MBD child, which includes medial measures at home and school. It's currently the ug of choice in many MBD uations.[1]



Ritalin is well tolerated. It n help control the excessive otor activity of the MBD child d ameliorate behavioral and rning problems.

Of course, Ritalin is not dicated for childhood personality and be- vioral disorders not associated with MBD.

ference
Charlton, M. H.: Paper presented at the Annual Convention of Medical Society of the State of New York, New York, N.Y., 7, 1971.

talin® hydrochloride ©
ethylphenidate hydrochloride)

BLETS

DICATION
nimal Brain Dysfunction in Children—as adjunctive therapy to er remedial measures (psychological, educational, social)
ecial Diagnostic Considerations
ecific etiology of Minimal Brain Dysfunction (MBD) is unknown, d there is no single diagnostic test. Adequate diagnosis requires e use not only of medical but of special psychological, educa- nal, and social resources.
e characteristic signs most often observed are chronic history of ort attention span, distractibility, emotional lability, impulsivity, d moderate to severe hyperactivity; specific learning disabilities; rceptual motor impairment; minor neurological signs and abnor- l EEG. The diagnosis of MBD must be based upon a complete story and evaluation of the child and not solely on the presence of e or more of these signs.
ug treatment is not indicated for all children with MBD. Appro- iate educational placement is essential and psychological or social ervention may be necessary. When remedial measures alone are sufficient, the decision to prescribe stimulant medication will pend upon the physician's assessment of the chronicity and severity the child's symptoms.

)NTRAINDICATIONS
rked anxiety, tension, and agitation, since Ritalin may aggravate ese symptoms. Also contraindicated in patients known to be hyper- nsitive to the drug and in patients with glaucoma.

ARNINGS
talin is not recommended for children under six years, since fety and efficacy in this age group have not been established. nce sufficient data on safety and efficacy of long-term use of talin in children with minimal brain dysfunction are not yet avail- le, those requiring long-term therapy should be carefully monitored. talin should not be used for severe depression of either exogenous endogenous origin or for the prevention of normal fatigue states. talin may lower the convulsive threshold in patients with or without prior seizures; with or without prior EEG abnormalities, even in absence of seizures. Safe concomitant use of anticonvulsants and Ritalin has not been established. If seizures occur, Ritalin should be discontinued.
Use cautiously in patients with hypertension.

Drug Interactions
Ritalin may decrease the hypotensive effect of guanethidine. Use cautiously with pressor agents and MAO inhibitors. Ritalin may inhibit the metabolism of coumarin anticoagulants, anticonvulsants (phenobarbital, diphenylhydantoin, primidone), diphenylbutazone, and tricyclic antidepressants (imipramine, desipramine). Downward dosage adjustments of these drugs may be required when given concomitantly with Ritalin.

Usage in Pregnancy
Adequate animal reproduction studies to establish safe use of Ritalin during pregnancy have not been conducted. Therefore, until more information is available, Ritalin should not be prescribed for women of childbearing age unless, in the opinion of the physician, the potential benefits outweigh the possible risks.

Drug Dependence
Ritalin should be given cautiously to emotionally unstable patients, such as those with a history of drug dependence or alcoholism, because such patients may increase dosage on their own initiative.
Chronically abusive use can lead to marked tolerance and psychic dependence with varying degrees of abnormal behavior. Frank psychotic episodes can occur, especially with parenteral abuse. Careful supervision is required during drug withdrawal, since severe depression as well as the effects of chronic over-activity can be unmasked. Long-term follow-up may be required because of the patient's basic personality disturbances.

PRECAUTIONS
Patients with an element of agitation may react adversely; discontinue therapy if necessary. Periodic CBC and platelet counts are advised during prolonged therapy.

ADVERSE REACTIONS
Nervousness and insomnia are the most common adverse reactions but are usually controlled by reducing dosage and omitting the drug in the afternoon or evening. Other reactions include: hypersensitivity (including skin rash, urticaria, fever, arthralgia, exfoliative dermatitis, and erythema multiforme with histopathological findings of necrotizing vasculitis); anorexia; nausea; dizziness; palpitations; headache; dyskinesia; drowsiness; blood pressure and pulse changes, both up and down; tachycardia; angina; cardiac arrhythmias; abdominal pain; weight loss during prolonged therapy. In children, loss of appetite, abdominal pain, weight loss during prolonged therapy, insomnia, and tachycardia may occur more frequently. Toxic psychosis has been reported.

DOSAGE AND ADMINISTRATION
Children with Minimal Brain Dysfunction (6 years and over)
Start with small doses (*eg*, 5 mg before breakfast and lunch) with gradual increments of 5 to 10 mg weekly. Daily dosage above 60 mg is not recommended. If improvement is not observed after appropriate dosage adjustment over a one-month period, the drug should be discontinued.
If paradoxical aggravation of symptoms or other adverse effects occur, reduce dosage, or, if necessary, discontinue the drug.
Ritalin should be periodically discontinued to assess the child's condition. Improvement may be sustained when the drug is either temporarily or permanently discontinued.
Drug treatment should not and need not be indefinite and usually may be discontinued after puberty.

HOW SUPPLIED
Tablets, 20 mg (peach, scored); bottles of 100 and 1000.
Tablets, 10 mg (pale green, scored); bottles of 100, 500, 1000 and Strip Dispensers of 100.
Tablets, 5 mg (pale yellow); bottles of 100, 500, and 1000.

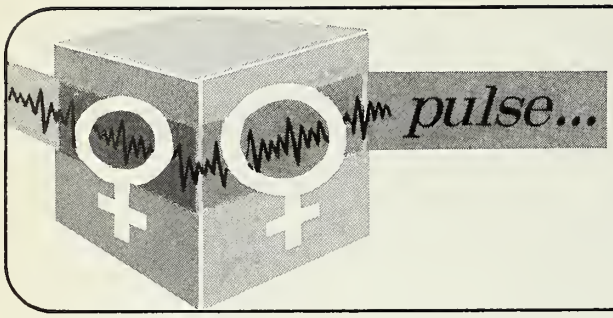
Consult complete product literature before prescribing.

CIBA Pharmaceutical Company
Division of CIBA-GEIGY Corporation
Summit, New Jersey 07901

2/4754 17

Ritalin®
(methylphenidate)
only when medication is indicated

C I B A



pulse... of the doctor's wife

Mrs. Roseanne K. Frank, *Editor*

From the Presidents Desk . . .

We're on our way! We've launched our space ship on our way to the stars. The momentum we gained at Convention is carrying us toward our charted destinations, and we are beginning to feel the exhilaration of the star-trip through 1973-74. At the Post-convention Board meeting, March 28, and on recommendation of the Executive Committee, the Board adopted three goals for the coming year. They are as follows:

1. Promotion of membership
2. Communication in relation to our own individual responsibilities
3. Promotion of legislative understanding and action.

Each of us is a member of the membership committee and each one of us is, therefore, responsible for positive action. Let's discover a new 'star' by matching one new member for each of us.

Individual responsibilities carry certain obligations which our "How to . . ." manual has spelled out for us. To be effective, however, we must share our ideas, our knowledge and our accomplishments with each other, through total communication, thus fulfilling our second aim.

It is not difficult to have at hand basic knowledge regarding legislative proposals and concerns regarding medicine and health. We have untold resources available and there should be no reason for failing to accomplish goal three.

We're on our way!

Mrs. Robert R. Hartman
President

Convention Musings

Were you at convention? Then you know how exciting it was! Did you miss it? That is too bad, because it is a good opportunity to meet friends from around the state, to get new ideas for projects for your auxiliary activities in the counties. There were some highlights:

The presence of our own Mrs. Scrivener who is on her way to great doings in the national Auxiliary to the AMA. The High Tea given for her was a gala occasion, made much pleasanter because our husbands took the time to help honor her.

The President's luncheon was a challenge to the hotel—so many attended! The I. Magnin fashion show had something to do with that. The table at which were seated our past presidents came in for its share of attention.

You missed other 'goodies' too numerous to mention, like a Champagne breakfast, etc. Then there was the serious business to attend to in the running of the auxiliary. The county reports of such projects as the "Time Bank" of the Will-Grundy auxiliary. You will be hearing more about this, and other creative approaches to auxiliary activities in future issues. ◄

1973-74 WA/ISMS Board of Directors



Newly elected WA/ISMS Board of Directors pictured are (from left):

Front row: Mrs. Wendell Roller, Mrs. Robert Swanson (Executive Secretary) and Mrs. Leo Kempton.

Second row: Mrs. Ralph White, Mrs. Joseph Shanks, Mrs. Thomas Glatter, Mrs. Robert Hartman, Mrs. Franklin Yoder, Mrs. Bernard Baalman and Mrs. August Martinucci.

Third row: Mrs. Joseph O'Donnell, Mrs. Oliver Renaud, Mrs. Sherman Arnold, Mrs. Paul Raber, Mrs. Wm. Schowengerdt, Mrs. Donovan Stiegel, Mrs. Stanley Burris, Mrs. Robert Webb, Mrs. John Ovitz and Mrs. Maynard Shapiro.

Fourth row: Mrs. John Koenig (back of Mrs. O'Donnell), Mrs. Clement Cunningham, Mrs. Lewis Bailen, Mrs. Frank Lippi, Mrs. Ralph Davis, Mrs. Robert Kooiker, Mrs. Irving Frank, Mrs. Joseph Santiago, Mrs. David Weaver, Mrs. Kenneth Furlong, Mrs. Alan Taylor, Mrs. Newton DuPuy and Mrs. Wm. Hodges.

Not pictured were: Mrs. Stuart P. Lippert, Mrs. Emanuel Herzon, Mrs. John Hubbard, Mrs. Renato Souza, Mrs. Earl Klaren, Mrs. Carell Hutchinson, Mrs. Richard Bowman, Mrs. E. J. Feinhandler, Mrs. John Holman, Mrs. Wilson West, Mrs. W. W. Davidson, Mrs. Harlan Failor, Mrs. Don Tomlin, Mrs. Mitchell Spellberg and Mrs. Robert Lee.

From the New Editor's Desk . . .

Help!

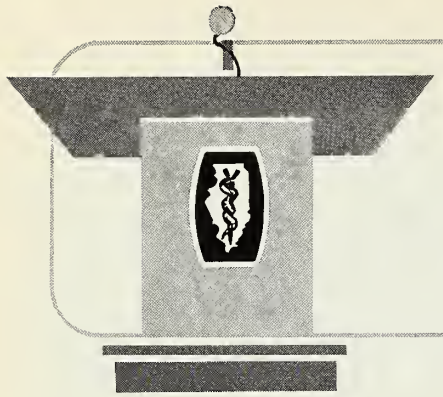
You have a new editor because I could not resist the persuasive new president of the auxiliary! Or—to put it another way one could say I did not have sense enough to say "no" when asked! However, with your help, we can make these pages of PULSE a meaningful way of keeping in touch with activities and plans throughout the state.

We are still involved in attempting to find a format which will be an instrument for reaching our membership, and the funding to finance it, since it would seem that too many times these pages in the IMJ are overlooked.

To have a newsletter we must have news. It must be timely, so send it IMMEDIATELY. We must have PICTURES to make it interesting. Those pictures must have information so that we can readily identify individuals.

This is your publication. May I hear from you?

Mrs. Irving Frank, Editor
135 S. Sacramento
Sycamore, Illinois 60178



What goes on

a guide to continuing education

Editor's Note: Information for the "What Goes On" page should be received two months prior to the event. Address all correspondence to the Illinois Medical Journal, 360 N. Michigan Ave., Chicago, 60601.

May 23–Martha Washington Hospital

Lecture: "Diagnosis and Antibiotic Therapy of Bacterial Pneumonia"

This lecture will be given by George A. Pankey, M.D., Clinical Associate Professor of Medicine, Tulane University School of Medicine, New Orleans.

Contact: Fernando Lopez-Fernandez, M.D., Medical Director, Martha Washington Hospital, 4055 N. Western Avenue, Chicago 60618

Martha Washington Hospital, Chicago

May 23–Loyola University

Problems in Pediatric Office Practice–Pediatric Roundtables

This is one in a series of one day presentations on recent advances in the diagnosis and therapy of pediatric diseases.

Each roundtable will feature a distinguished visiting faculty member and three additional speakers from the local pediatric community. There will be formal presenations which will be clinically oriented supplemented by case discussions.

Registration: $10.00

Contact: Pediatric Roundtables, c/o Eugene F. Diamond, M.D., 2160 S. First Avenue, Maywood, IL. 60153

Loyola University Medical Center, Maywood

May 24–National Training Center on Drug Abuse

Clinical Workshop on Drug Treatment

This program will be held in cooperation with IHA, ISMS, the Illinois Nurses' Association and the Illinois Pharmaceutical Association.

This clinical program is aimed at physicians and emergency room personnel. It will deal with emergency room techniques for dealing with drug overdose.

Contact: Illinois Hospital Association, 840 N. Lake Shore Dr., Chicago, IL 60611.

Registration: $5

Rock Island, IL.

June 14-16–University of Wisconsin

Three-Day Reproductive Endocrinology Conference

The program will be a series of panels and workshops to acquaint physicians with recent advances in endocrinology. The sessions will give attending physicians the opportunity to meet in a number of small group discussions with leaders in the field.

Topics will include female endocrine problems, reproductive genitics, infertility, contraceptive problems and postmenopausal endocringology. The conference will serve as both a review of the important aspects of endocrinology and as an aid to physicians in offering better care to patients that require this type of medical attention.

Contact: Department of Postgraduate Medical Education, 610 Walnut St., Madison, WI. 53706

Wisconsin Center, University of Wisconsin–Madison Campus

June 15-17–American Academy of Air Traffic Control Medicine

Second Annual Seminar on Stress

This program is designed for professionals and all others concerned with air traffic safety to provide in-depth presentations by leaders in the field of basic concepts of and recent developments in the effects of stress in impairing efficiency and welfare.

Special emphasis and attention will be given the occupation of air traffic control because its members are particularly exposed to forms of stress which exemplify the rigors of modern technological pressures. The meeting will be conducted in the manner of a seminar; each speaker will be provided with adequate time for a thorough presentation of his subject and ample opportunity for involvement of all interested in the discussion.

Fee: Member, $50.00/Nonmember, $75.00/Students, Free

Contact: American Academy of Air Traffic Control, 103 W. Main St., St. Charles, IL. 60174

Sheraton-Chicago Hotel, Chicago

June 23-July 2–American Medical Association

Annual Meeting–Clinical Conference

Fees: Members Free, Non-members $25,00, Guests of Non-members $5.00 and Medical Students $10.00.

Contact: Margaret Jordan, AMA, 535 N. Dearborn, Chicago (312) 527-1500.

Scientific Portion

Post-Graduate Courses

The Colosseum and New York Hilton

Physician Recruitment Program

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program. This is a free service to all physicians.

Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 360 North Michigan Ave., Chicago, 60601.

ALBION: General Practitioner. Population 1,800, trade area 13,000 with only 4 physiicans in area. Office facilities, financial assistance available. Rural setting, county seat town; expanding economy, hospitals nearby. City park, swimming pool, tennis courts, etc. Unit school district, Community College 15 minutes. Contact: Don Broster, Citizens National Bank, Albion, 62806, 618-445-2344. (4)

AVON: General Practitioner. Population 1,000, trade area 3,500 to 4,000. Rural practice. Twenty-four bed hospital in town. Office facilities available. Recreational facilities nearby. Excellent area in which to practice and raise a family. Contact: Fred L. Janes, Avon, 61415, 309-465-3883. (4)

ALEDO: Mercer County, 17,000 population, needs additional family physicians. 4 active physicians at present. General acute hospital in Aledo. High quality medical care economically rewarding. Thirty miles from metropolitan quad-city area. Good small community for family living. Contact: Shirley Lindberg or Monty McClellan, M.D., 308 NW Forth Street, Aledo, 61231, 309-582-5156. (9)

BLOOMINGTON-NORMAL: Population 80,000. General Practitioner in 3 man partnership—25 year establishment. Complete office, Lab., & X-ray facilities. Salary first year and full partnership thereafter. Three hospitals available, but only one used. Housing available—rent or buy. 90 miles from Chicago Loop. Contact: Homer C. Lyman, M.D., 5 Citizens Square, Normal. 309-452-1151. (8)

BUNKER HILL: Population 2,000; friendly community. Opening for general practitioner. Five hospitals within a 30 mile area. No recreational facilities, but we need you. Surrounding country practice. Contact: Frances S. Stadelman, 110 W. Warren St., Bunker Hill, 62014, 618-585-4565. (5)

BUSHNELL: General Practitioner. Where a doctor can have a family life. Population 3,800. Literally minutes from stocked lakes, water sports. Good hunting. Your dream home costs less. State University close by. Our doctor did Europe all September. Visit there, come home here. Contact: Jack Gordon, Box 150, Bushnell, 61422. 309-772-3141. (4)

CARBONDALE: 25 man multi-specialty in southern Illinois needs Internists, Dermatologist, OB-GYN, Family Practitioners. Generous salary and fringe benefits, early partnership. New, modern building. Developing medical school. Contact: Wayne Given, P.O. Box 1030. Carbondale. 618-549-5311. (4)

CARLINVILLE: G.P., I.M., Ped., OB-GYN. Population 5,700. Mid-way between St. Louis and Springfield. Serves 30-mile trading area of 50,000 population. Newly built physicians building adjacent to hospital. Modern office space for doctors. Modern 68-bed hospital fully equipped and staffed. Opportunity for building large practice. We need doctors. Contact: James Rives, Carlinville Area Hospital, Carlinville, 217-854-3141. (7)

CARROLLTON: You can't match or beat the medical opportunities in Greene County for a Family Physician. Group practice being set-up in a new office building near hospital. For further information write or phone: Drs. Caselton or Wilson or Ray Shoemaker, Carrollton, 62016, 217-942-6946. (4)

CANTON: Urologist and Pediatrician needed by 12-man multi-specialty group. Aggressive city of 15,000 thirty minutes from Peoria. Excellent starting salary leading to full share in corporation. Tax savings and pension plan. Many recreational activities in area. Contact: S. C. Johnson, Coleman Clinic Limited, 175 S. Main St., Canton, 61520, 309-647-0201. (5)

CASEY: G.P. wanted to join Medical Center Staff; lab, X-ray, P.T., remote EKG, IPPB, 2 Observ. Rooms, 2 Emerg. Rooms, 24 hr. Emerg. Ser. call every 4th wkend, 1 wk. day, pleasant community, good schools, numerous churches, exceptional recreational facilities, golf course, country club, airport. Contact: Howard G. Johnson, Casey Medical Center, Box 427, Casey, 62420, 217-932-4061. (4)

CHADWICK: General Practitioner. Population 600. Office facilities available. Former physician left practice of twelve years to retire to West Coast. Five minutes from country club and twenty minutes from Mississippi River. Contact: LeRoy Foltz, 329 Marion, Chadwick, 61014, 815-684-5128. (4)

CHAMPAIGN-URBANA: Opportunities for Neurologist, Nephrologist, Internists, and Orthopedist in prospering 30-man group. One-third of doctors under 35. Affluent Big-10 town of 90,000 with top schools and real cultural/recreational attributes. Full Associateship after 18 months on excellent guarantee. Write or call collect: Joseph A. Zalar, Jr., M.D., Christie Clinic, Champaign, 61820, 217-384-1240. (4)

CHICAGO: Field Clinic has opening for an Internist with a specialty either in allergies, rheumatology, or gastroenterology. Salary is open. The Field Clinic is one block from Ravenswood Hospital, which is a 400 bed medical center. Contact: Kenneth Hatfield, M.D., 4600 N. Ravenswood Ave., Chicago 60640. 312-275-7700. (8)

CHICAGO: Local Medical Examiner, half or fulltime, 5 days, M-F. Large company downtown with professional staff, modern facilities, needs Illinois licensed internist, G.P., or surgeon. Salary negotiable, excellent benefits. Call 431-4671 or write Room 708, 122 South Michigan, Chicago, 60603 for information. (9)

COAL CITY: General Practitioner. Growing community, with trade area of 15,000, offers to a physician a completely equipped office. Free for six months. Only one hour from Chicago, three hospitals nearby, and great recreational facilities for leisure. Contact: John Nicoletti, Coal City, 60416, 815-643-8608. (4)

DE KALB: 33,000 Population. University town. Good schools—all religious denominations. Complete office facilities—X-ray & Lab.; with 6 physicians—including OB-GYN, General Surgeon, Family Practitioners. Need Internist & Family Practitioner. Financial assistance available. Contact Gordon Graham, 901 N. First, De Kalb, 60115, 815-756-6611. (4)

DU QUOIN: Population 7,000, 75 miles South of St. Louis and 20 miles north of Southern Illinois University. 1 Surgeon and 1 General Practitioner & OB GYN. Excellent opportunity for both to build lucrative practice. Brand new hospital with all new equipment and facilities. Present hospital board and staff will support. Office spaces can be made available. Area has good recreational facilities, good school and shopping areas. Contact W. M. Thornburg, M. D., 111 W. Main St., Du Quoin 62832 618-542-2137. (9)

EFFINGHAM: Service area 60,000—Central Illinois at intersection of I-57 and I-70. G.P.s, OB-GYN, Urology, Orthopedic Surgeon, Internal Medicine. Clinic or solo practice. Progressive community. Contact: Don Kabbes, 503 North Maple Street, Effingham, 62401, 217-342-2121. (4)

EVANSVILLE: General Practitioner. Population 1,000 with a large rural area. We are 15 minutes away from any one of three new hospitals. We stand ready to build to one or two doctors' needs. Also, we have financial assistance available. Contact: Jim Biethman, Box 144, Evansville, 62242, 618-853-2629. (4)

FAIRFIELD: General Practitioners Wanted. Are you bored and want a challenge? Do you want to practice where they don't ask about your diploma, or your specialty? Are you genuinely interested in people and their problems, rather than diseases and cases? If so, come on down to Fairfield and get your feet wet! Write or phone collect: Jerry Vaughan, Box H, Fairfield, Illinois 62837, 618-842-2167. (12)

FAIRFIELD: G.P. or internist interested family practice to join group three physicians—GP, board surgeon, board OB-GYN man—town 6,500 population. Generous salary, full association one year, if mutually agreeable. Excellent hospital in town. Interview and all expenses paid. Contact Sigmund Konarski, M.D. 101 E. Center St., Fairfield, 62837, 618-842-2187. (10)

FLORA: Population 6,000. G.P., Int., OB-GYN, Ortho. Surg., Anesth., Ophth., ENT. Group or solo practice. Nine physicians at present. One hundred miles east of St. Louis on Route 50. Financial assistance available. Excellent school system. Outstanding parks and recreational facilities. Visit at our expense. For an appointment contact: Alvin J. Uebinger, Administrator, Clay County Hospital, P.O. Box 280, Flora, 62839, 618-662-2131. (4)

FREEPORT—Population 30,000. Internist & Pediatrician urgently needed to join a corporate 9 man multispecialty group. Established in 1948, new building in 1970. Salary first year. Fringe benefits include $50,000 life policy and retirement plan. For additional information—Freeport Medical Clinic, Ltd., Freeport, 61032, K. H. Shons, Business Manager, 815-233-6131. (9)

GALESBURG: Galesburg Clinic. Population 40,000. Twelve man multispecialty group seeking Ophthalmologist, Orthopedist, Internists, Urologist and Family Physician. New clinic building connected to new hospital. Home of Knox College. Excellent schools, recreational and transportation facilities. A fine opportunity. Contact: L. S. Doyle, Administrator, 320 North Kellogg St., Galesburg, 61401, 309-342-1161. (4)

GENESEO: Ped., OB-GYN, F.P., Orth. Surg., Int. Med. Population 7,000 serving area 30,000 on Interstate 80, 2½ hours from Chicago, 25 miles from Quad-Cities metropolitan areas, over 300,000. Safe, ideal, small city living, 110 bed ultra-modern hospital, excellent schools, recreational facilities. Clement G. McNamara, 210 W. Elk St., Geneseo. Call collect 309-944-6431. (4)

GIBSON CITY: Int., Ped., OB-GYN, F.P. Rural community with hospital facilities. Half-hour to Champaign-Urbana or Bloomington-Normal or two hours to Chicago Loop. Office facilities are available as well as financial assistance if necessary. Contact: Robert E. Jones, Gibson Community Hospital, Gibson City, 60936, 217-784-4251. (4)

HARVARD: Population 5,200, estimated trading area 20,000. Three physicians at present, previously five. Center of rapidly growing area and financially sound. Sixty five miles northwest of Chicago, thirty miles east of Rockford. Community committee, including present doctors. Contact: Mrs. Catherine K. Oost, 58 N. Ayer St., Harvard 60033. 815-943-5261. (9)

HERRIN: Int., G.P., ENT, Anesth. Population 10,000-trade area 40,000. Near S.I.U., 90 miles to St. Louis. New offices, modern hospital. Beautiful vacationland, all outdoor sports. Financial assistance and salary guaranteed. Call collect Larry Feil 618-942-4710, Herrin Hospital, Herrin, 62948. (9)

ILLINOIS DRUG ABUSE PROGRAM: Full or part-time work in general medicine, psychiatry, research, administration, or any combination of the above. Excellent opportunities for treating all types of chemical dependence, as well as carrying out research on medical and psychiatric aspects of the addiction problem. Also, full or part-time work in special units including alcoholism, severe medical and psychiatric problems, and a discreet operation serving pregnant addicts. Contact: Edward C. Senay, M.D., 5700 S. Lake Shore Drive, Chicago, 60637, 312-955-9800. (4)

LAKE FOREST: Internists, certified or eligible, needed to practice in fine north shore community, with excellent earning potential. University appointment desirable. Excellent hospital with all specialist medical staff. Contact: Steven L. Seiler, Lake Forest Hospital, Lake Forest, 60045, 312-234-5600. (9)

LEROY: Population 2,500. Opening due to death of only physician. Large practice. Excellent clinical and office facilities. Financial assistance available. For complete information, contact: Al Provasi, 307 N. Chestnut St., LeRoy, 61752, Phone: Res. 309-062-5101; Bus. 309-962-2721 or Craig Pillatsch, 101 W. Center Ct., LeRoy, 61752, Res. 309-962-7781; Bus. 309-962-7171. (5)

LIBERTYVILLE: Family Physician wanted for medical group of three Family Practitioners. Originated in 1952—Incorporated in 1964—Remodeled in 1972. Fringe benefits: hospitalization, pension, profit sharing, bonus and others. Complete office facilities. Please Contact: Mark H. Fields, Jr., M.D., 716 S. Milwaukee Avenue, Libertyville, 312-362-1390. (4)

LITCHFIELD: F.P., OB-GYN, Ped., Int. Population 7,300, Trade Area 50,000 in 15 mile radius. New 134 bed hospital. Midway between Springfield and St. Louis, Mo. on I-55. Good schools. Good recreational facilities. Financial assistance can be arranged. Contact: John Short, 723 N. Van Burean, Litchfield, 62056, 217-324-3937. (4)

MACOMB: G.P., Int., Ped. Population 19,000. Home of Western Illinois University. 200 bed open staff hos-

pital. Modern offices available for solo or clinic practice in all specialties. Guarantee plus fringes. No pollution, crime or traffic problems. Rural living with urban culture and recreation. Contact: D. H. Dexter, M.D., Macomb Clinic, Doctors Lane, Macomb, 61455, 309-833-4176. (4)

MARSHALL: General Practitioner. A new medical center now open located 17 miles from Terre Haute where hospital is available. Recreational services include fishing and camping. Another lake is under construction for boating and swimming. Excellent schools. Financial assistance available. Contact: Donald B. Smitley, Cork Medical Center, 410 N. 2nd St., Marshall, 62441, 217-826-2361. (4)

MAYWOOD-DIXON: Population 35,000 and 20,000 respectively. Expanding multispecialty groups, directed towards comprehensive medical care—excellent opportunities for Internist, General Surgeons, Pediatricians, Emergency Room Physicians—now and in the future. Contact: Gene M. Gaertner, M.D., 1908 St. Charles Rd., Maywood, 60153, 312-344-5300. (4)

METROPOLIS: Physicians wanted. F.P., OB-GYN. Complete office facilities. Financial assistance available. Modern, well equipped hospital serving tri-county area in scenic southern Illinois. Contact: Charles Russell, Administrator, Massac Memorial Hospital, Metropolis, 62960, 618-524-2176. (4)

MOMENCE: General Practitioner. Population over 4,000. Opening new health center 14 mi. from Kankakee and 50 mi. from Chicago on Route 1. Office facilities available—some financial assistance available. Contact: Rachel Simpson, 210 N. Dixie, Momence, 815-472-2751; or George Duguay, N. Dixie Hwy., Momence, 815-472-4833. (4)

MONMOUTH: Services area population 30,000. Opening for General Practice and General Surgeon with training in Orthopedics and/or Vascular Surgery. Modern well-equipped hospital—141 beds. Near Highways I-74 & I-80. Daily rail to Chicago. Flight service available. Safe place to raise family. Near medical school, liberal arts college. Contact: Roger E. Gurholt, 1000 W. Harlem Ave., Monmouth, 61462, 309-734-3141 X 261. (4)

MONTICELLO, IOWA. Trade area 15,000. Need six or seven additional doctors. Presently served by four physicians, all involved in General or Family practice. Could afford some specialties in combination with General Practice. Financial assistance available. Contact: John Wild, c/o John McDonald Hospital, Monticello, Iowa, 319-465-3511. (4)

MT. CARMEL: General Practitioner. Population 8,100. Medical service center for 25,000 population. Complete medical facilities. Five doctors at present. Rapidly growing area. All recreational and cultural facilities nearby. Assistance available. Contact: Walter Curry, 200 Lambert Drive, Mt. Carmel, 62863, 618-262-4534. (4)

OLNEY: Weber Medical Clinic, 23 man multispecialty group. Population 100,000+, new building, patient load increased 20%. OB-GYN, Orth., Int., Ophth., Oto., Derm., Urol.; 5 weeks vacation, 1 week educational leave per year, pension plan, life insurance, disability. Lovely community, no ecology problems. Contact: David L. Potter, Adm., 1200 N. E. St., Olney, 62450, 618-395-2223. (4)

OTTAWA: Population 20,000. Opening in Internal Medicine at the Ottawa Medical Center, S.C. Eight-man specialty group. Seventy-five minutes from Chicago Loop. New hospital opening date in October, 1973. Contact: D. E. Morehead, M.D., 313 W. Madison St., Ottawa, 61350, 815-433-1010. (5)

PANA: We need 2 physicians to practice general medicine in a friendly active community of 6,500. 45 minutes from Springfield or Decatur, 1½ hours from St. Louis. Economy is farming and light industry. 5 schools, 16 churches, parks, clubs, lakes, etc. Contact John Luff, Pana Hospital, Pana, 62557, 217-562-2131. (9)

PAW PAW "Rent Free" modern clinic available: Progressive, growing community, wishes to locate services of general practitioner. Modern medical, dental clinic provided. Maintenance of brick building by occupants only requirement. Excellent opportunity for profitable practice, plus ideal family living in friendly small town atmosphere. Contact: Mrs. Darlene McLaughlin, Paw Paw, 815-627-8441. (5)

PEORIA: Population 325,000. Emergency Room position for fulltime physician. Located midway between Chicago, St. Louis, and Iowa City. Excellent minimum salary and benefits. 824 bed community general teaching hospital, affiliated with University of Illinois Medical School. Illinois State Regional Trauma Center. Contact: Personnel Director, St. Francis Hospital, Peoria, 61603, 309-672-2304 (4)

PINCKNEYVILLE: Population 3,500. Opening in small Group-Partnership for Family Physician. Fully accredited hospital. Complete office facilities. No financial investment. Excellent compensation and working conditions. Sixty miles from St. Louis. Good recreational facilities. Contact: Clarence E. Cawvey, M.D., 206 No. Main St., Pickneyville, 62274, 618-357-2131. (4)

PLYMOUTH: Population 800 plus large rural drawing area. Ten-year-old clinic & office building (large) available. Two closest hospitals 18 miles. Large Illinois University 18 miles. Golf course, hunting, fishing, etc. close by. Grade and high school in town. Contact: Ken Smith, Box 21, Plymouth, 62367, 309-458-6241. (9)

PONTIAC: Population 11,000. 100 miles south of Chicago on Route 66. 10 physicians. Several retiring. Wanted: Family Practitioners, General Surgeon (one on staff), Internal Medicine (none on staff). Paid Emergency Room coverage available. Financial and office space available. Contact: Dale Buddle, 610 East Walter St., Pontiac, 61764. Call collect: 815-844-5134. (4)

PRINCETON: Population 7,800; county population 38,000. Excellent living conditions; good family community—no problems. Modern 180-bed hospital. Unlimited income for Family Physiicans and Pediatricians. 2 hours—Chicago; 1 hour—Peoria & Quad Cities on I-80. Call collect: John Revell, 606 South Main St., Princeton, 61356, 815-872-1255 or 815-875-3292. (4)

PROPHETSTOWN: Small town boy?? If you are a physician interested in General Practice, and want a small town life for your family, then Prophetstown may be the place for you. We invite your inquiries. Contact: Calvin W. Schuneman, 343 Washington Street, Prophetstown, 61277, 815-537-2301. (4)

QUINCY: OB-GYN, Ped., Ortho., Fam. Prac., Derm., Int. Med. to join 17-man established clinic. Large modern clinic, many benefits, two well-equipped hospitals. Excellent schools, cultural, recreational advantages. Good family city. Above average earnings. Write or call collect: Mr. Judson C. Green, Quincy Clinic, 1400 Main St., Quincy, 217-222-6550. (4)

RANSOM: General Practice Opening. Death compels sale of practice. Modern equipment and brick building—consists of doctor's, nurses and receptionist's offices, large reception room, laboratory and office-treatment rooms. 80 miles southwest of Chicago. St. Mary's Hospital staff in Streator, practice reaches a 50 mile radius. Contact: Mrs. D. Jones, Ransom, 60470, 815-586-4229. (4)

RIDGE FARM: Population 1,015. Seventeen miles south of Danville. No physician at present. Complete office facilities. Financial assistance available if needed. Contact: Nolin Weathers, 207 E. North St., Ridge Farm 61870. 217-247-2265. (8)

ROANOKE: General Practitioner. Population 2,050. Opening for one or two physicians. Excellent location for clinic-type facility. Financial assistance available. Space available, or will build to suit. Twenty-five miles from Peoria and Bloomington. All recreational facilities nearby. Contact: Elton Ulrich, Savings Building, Roanoke, 61561, 309-923-2831. (4)

ROSICLARE: G.P., Ped. Hospital serves 2 counties-approximately 10,000 people. Three Physicians at present. Office facilities, financial assistance & housing available. Modern, well equipped hospital. Located on Ohio River and in recreational area. Contact: Loeta Allen, Hardin Co. General Hospital, Rosiclare, 62982. Call collect: 618-285-6634. (4)

SALEM: G.P., Ped. Growing community with large rural area to serve. Financial assistance available. Fine schools and other municipal services. New 60-bed hospital addition under construction. Eighty miles from St. Louis. Contact: Edris Bachman, 520 Markland, Salem, 62881, 618-548-1944. (4)

SANDWICH: Population 5,500. 92-bed hospital serving 30,000. Need for two or three General Practice Physicians plus Internist plus Obstetrician plus Pediatrician. Single or group practice opportunities. The good life is here including economics, and also an hour from the Loop, etc. Contact: Marvin Tice, 11 East Pleasant Avenue, Sandwich, 60548, 815-786-8484. (4)

SAVANNA: G.P., Int. 5,000 population on Mississippi River. 40 bed open staff hospital. Excellent recreational facilities, excellent schools, churches of all denominations. Option to practice alone or in partnership. Financial assistance available. Contact: Wm. Dayton, 202 Meadow View Knoll, Savanna, 61074, 815-273-2221. (4)

SENECA: Wanted Family Physician—population 2,500, 70 miles southwest of Chicago. No doctor in town. Beautiful office building and equipment. Offer free rent with option to buy. Guarantee monthly gross. General Surgery knowledge helpful but not necessary. Two new hospitals—12 miles away with country driving. Contact: Marion L. Osborne, 135 E. Lincoln St., Seneca, 61360, 815-357-6172. (4)

SHERIDAN: General Practitioner. One or two doctors for modern medical center. Financial assistance available including part-time staff physician for state institution. Excellent hospital facilities. Good opportunity for doctor who enjoys his family. Contact: John Yuhas, Sheridan, 815-496-2272 days or Alvin Sebby, Sheridan, 815-496-2620 evenings or weekends. (4)

SOUTHWESTERN TERRITORY: General Practitioner, towns of Brighton, Medora, Piasa, Shipman, combined area population 7,500. Office and facilities available; partnership and or financial assistance available. Five general hospitals in surrounding area, country living, excellent churches, schools, shopping areas. St. Louis and Springfield one hour away. Contact: Kenny Lahr, Piasa, 62079, 618-729-4142. (4)

STREATOR: Population 18,000. Multispecialty group, 7 physicians at present. New air-conditioned facility across from St. Mary's Hospital. Guaranteed minimum salary. Incorporated. Paid vacation and post-graduate study. Excellent insurance benefits. All specialties needed urgently. Contact: Dr. C. T. Hawkins, Streator Medical Clinic, S. C., 104 Sixth Street, Streator, 60364, 815-672-0511. (4)

STRONGHURST: Progressive small town serving large rural area. Close to large advanced medical facilities, recreational facilities nearby. No racial or environmental problems. Contact: Robert Dillon, Stronghurst, 61480, 309-924-6411. (4)

TAYLORVILLE: Population 12,000. Two-year old, seven physician multispecialty clinic seeking General Practitioners, Internists and OB-GYN. Salary first year. Full partnership thereafter. 25 miles to Springfield and SIU Medical School. 90 miles to St. Louis. Many recreational facilities nearby. Contact: Tom Brewer, 600 N. Main Street, Taylorville, 62568, 217-824-8191. (4)

WASHINGTON: Population 10,000 plus, need family physician; financial assistance available, office of doctor, recently retiring, with some equipment available. Ten minutes from Peoria. All recreational facilities available in or near Washington. 1 year free use of car provided, 6 mo. rent free residence available. Contact: Dean R. Essig, 139 Washington Square, Washington, 61571. (7)

WATSEKA: Population 5,800. Opening in established medical clinic, 4 Physicians at present. Complete office faciilties. Lab & X-Ray. Need GP and Internal Medicine. Contact: Francis Carter, 845 S. 4th Street, Watseka, 60970, 815-432-2461. (4)

WATSEKA: Population 5,800. General Practitioners needed. Clinic or single opportunity available. 16 physicians at present. Eighty-five miles from Chicago. New facilities, 114-bed hospital. Specialist available. Contact: Administrator or Chief of Staff, Iroquois Memorial Hospital, 200 Fairman Street, Watseka, 60970, 815-432-5201. (7)

WITT: Physicians needed in section of county to serve over 20,000 people. A modern building complete and ready for two doctors. Financial assistance available. Country living with access to big city attractions, St. Louis, Mo. Contact: Louis Schwartz, Witt, 62094, 217-594-2431. (9)

WOODSTOCK: Population 11,000, close to Chicago, growing community, complete office facilities with laboratory and X-ray, new 150 bed hospital well equipped. Need internist and pediatrician. Contact: J. Tambone, Northwest Clinic S. C., 102 E. South St., Woodstock, 60098. 815-338-2345. (8)

WOODSTOCK: Int., Ped. to join young 9-man multispecialty group in rapidly expanding area 60 miles NW of Chicago—Excellent Hospital—1st year minimum ($30,000)—Full member after one year—No buy-in's. Contact: Dr. Pensinger, Kishwaukee Valley Medical Group, S.C., 13707 W. Jackson St., Woodstock, 60098, 815-338-6600. (4)

WOODSTOCK: Population 15,000. Two man corporation desires Generalist or Internist. Complete office facilities. 130-bed general hospital. Approximately 60 miles from Chicago. Salary open depending on qualification and experience, with partnership in 2 years if agreeable. Contact Dr. H. A. Stahlecker, Jr., & Dr. P. D. Exconde, 666 W. Jackson Street, Woodstock 60098, 815-338-2210 Collect. (9)

WONDER LAKE: Associate Wanted. Residential oasis on privately owned 12-mile shoreline lake. Summer-winter sports. Good schools, many churches. 55 miles from Chicago, Milwaukee, Rockford. Two local hospitals. Complete facilities for Family Practice. Contact: S. L. Ruggero, M.D. ABFP, Box 137, Wonder Lake, 60097. 815-653-2131. (8)

BLUE SHIELD REPORT FOR Illinois Physicians

Blue Cross Policy on Free Standing Ambulatory Surgical Facilities

INTRODUCTION

While Blue Cross believes that the surgical care of ambulatory patients should take place within licensed hospitals, and further, that hospitals should make special arrangements to facilitate the care of ambulatory patients, it is recognized that there may be exceptional circumstances where the development of a "free standing" ambulatory surgical facility may be appropriate. The following policy statement is intended for use by the management of Blue Cross in evaluating the qualifications of such free standing facilities:

POLICY

A free standing ambulatory surgical facility wishing to affiliate with Blue Cross as a member facility shall submit evidence that the facility and its staff does and will comply with the following minimum standards:

(1) The facility has been approved by an appropriate health planning agency serving the area in which the facility is located. The agency should, wherever possible, be a recognized comprehensive health planning agency with substantial consumer involvement. Where a planning agency is solely representative of providers, its evaluation of the need for, and program of, a free standing surgical facility should be subject to review by the appropriate comprehensive health planning agency at the regional or state level.

(2) At such time as standards for the accreditation of facilities are developed by the Joint Commission on Accreditation of Hospitals, or similar accreditation body, the facility should be accredited or should have applied for accreditation.

(3) The facility should be licensed by the appropriate State or local licensing body if licensing requirements have been established.

(4) The facility should not provide for the overnight care of patients within the facility.

(5) The facility should have permanent modern facilities and equipment consistent with the type of care that will be rendered, which at least meet local requirements for fire safety and sanitation and satisfactory operating procedures to protect the welfare of patients, visitors, employees and the medical staff.

(6) The facility should include, at least, an operating room, a recovery room and an adequate clinical laboratory. Complete radiology, clinical laboratory and other services need not be included in the facility but must be available through a formal arrangement between the facility and a Plan hospital or a free standing clinic, recognized by the Plan.

(7) The facility should have emergency equipment available to handle emergencies that may arise during the course of treatment of its own patients. Such equipment should include but need not be limited to:

- a defibrillator
- a tracheostomy set
- a supply of whole blood
- cardio-pulmonary resuscitation equipment

If the facility accepts responsibility for emergency cases, it should have the necessary equipment and personnel to provide such services. The facility should also have obtained the approval of appropriate planning and licensing bodies to provide such care.

(8) There shall be evidence that there is an identifiable governing authority which has assumed legal and moral responsibility for the operation of the facility. There should also be evidence that the governing authority has delegated authority to an individual or individuals for day to day operation of the facility in accordance with written policy statements that have been adopted by the governing authority.

(9) The facility should have an organized medical staff to which the governing authority has delegated responsibility for maintaining proper standards for medical and surgical care. The medical staff should have adopted by-laws which cover such matters as:

- Criteria and procedure for admission of physicians to the staff.

(Continued on following page)

- Criteria and procedure for determining the extent of surgical privileges.
- Content and form of medical records.
- Procedure for the review of clinical work.

The surgical privileges accorded individual members of the medical staff should not exceed the surgical privileges which have been extended to individual members of the staff by Plan hospitals. There shall be evidence that members of the medical staff have surgical privileges with the Plan hospital or hospitals with which the facility has transfer agreements.

(10) The governing authority and the medical staff of the facility should have developed and adopted a statement of the specific surgical procedures which will be performed within the facility.

(11) Each patient who is treated in the facility should be admitted by authority of a member of the medical staff and the care of the patient should remain under the supervision of the admitting physician or be transferred to another member of the medical staff. Adequate medical records should be maintained for each patient containing at least the following:

- Admitting diagnosis
- Report of medical history and physical examination
- Laboratory test results
- X-ray reports
- Operative reports
- Anesthesia records
- Pathological specimen examination reports
- Medications and care ordered and given
- Discharge summary

The medical staff and the governing authority shall adopt an operating policy which states that no patient shall be subject to surgical treatment until the patient's medical record contains at least a medical history, report of physical examination and appropriate test results, except in emergency.

(12) The medical staff shall have established and documented an active utilization review program to insure control over the quality of medical and surgical care. In addition, the staff should have a functioning Tissue Committee.

(13) The facility should show evidence that there is an adequate employee staff including registered professional nursing personnel. There should also be evidence that at least one physician is on the premises at all times when patients are under care. Anesthesia service should be performed by a qualified anesthesiologist or by a certified registered nurse anesthetist under his direct supervision.

(14) The faciilty should have a written transfer agreement with one or more general hospitals affiliated with the Plan. These hospitals or hospital should be within reasonable distance to facilitate the prompt transfer of patients requiring hospital care. The hospital should, through the agreement, agree to provide emergency and in-patient hospital care under the supervision of a member of its medical staff. The agreement should include the requirement that complete patient information shall be transmitted with the patient at the time of transfer. The hospital, as a party to the agreement, should have the right to review all care rendered in the facility.

(15) Payments for services rendered to Blue Cross members in the facility should be subject to the same cost reconciliation or prospective rate formulas and other controls which apply to hospital services and should be documented in a contract between the Plan and the facility.

ASK BLUE SHIELD . . . ABOUT MEDICARE

Examine Newly Issued Medicare Cards For Effective Date of Benefits

Under the new automatic enrollment procedure for Medicare benefits, including those for the disabled under age 65 and persons reaching 65 by July 1, 1973, the Social Security Administration will begin issuing health insurance cards in the third month *before the month* when beneficiaries are first entitled to Medicare coverage. Previously, new beneficiaries did not usually receive their cards until a few weeks before the effective date of coverage. In many cases cards were not received until after the effective date of eligibility for benefits. With the new system, beneficiaries will be in possession of identification cards well before the first month in which they are entitled to Medicare benefits.

The health insurance cards issued to the disabled and to renal dialysis beneficiaries will have no distinctive characteristics from those issued to beneficiaries age 65 and older. Neither the appearance of the card nor any special letter prefix or suffix on the claim number will indicate the basis for Medicare coverage.

Physicians and suppliers of Part B services should be alert to the absence of benefit identification and the effective date of Medicare coverage on the card. Possession, therefore, should not be the sole basis for assumption of Medicare coverage for newly enrolled beneficiaries.

SSA Change In Certification of Outpatient Physical Therapy Clinic

The request of the clinic listed below to withdraw from the Health Insurance for the Aged Program as a provider of outpatient physical therapy services has been approved by the Social Security Administration, and no payment will be made for such services to patients after May 10, 1973:

1300 Central Physical Therapy
1300 East Central Road
Arlington Heights, Illinois 60005
Provider Number 14-6507

IMJ
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Medicine: the Learned—and Learning—Profession

Is it possible to put a price tag on continuing medical education?

The Illinois State Medical Society believes no price is too high.

Our House of Delegates pledged half of the 1972 AMA-ERF assessment—over $93,000—as initial financing for the Illinois Council on Continuing Medical Education (ICCME). And at its March meeting, the House voted to contribute $10 of each member's 1974 AMA-ERF contribution to support ICCME activities next year.

Why have Illinois physicians invested so heavily in continuing education? Simply because we believe medical education is not only preparatory training, but also an essential characteristic of our entire professional lives. And ICCME unites the energies and resources of ISMS, Illinois physicians and the state's medical schools to meet our growing demand for CME.

Physician contributions have enabled ICCME, the nation's first such organization sponsored by a state medical society, to:

- Coordinate CME programs to make them more readily available to physicians;
- Develop new educational techniques.
- Assist planners in formulating quality education courses, and
- Encourage Illinois health institutions and county medical societies to initiate CME programs.

Last month, more than 100 representatives of specialty societies and medical schools joined other health professionals in ICCME's first Congress on Continuing Education—the first major effort to establish CME goals for Illinois and develop a statewide continuing education program.

Despite these efforts, some critics contend that we have not gone far enough or fast enough. They call for government to legislate requirements for periodic re-examination as a condition for relicensure.

Partly because of ISMS testimony, the Illinois Health Licensure Commission did not recommend legislative action on the re-examination requirement. It did, however, advocate a mandatory CME requirement for registration beginning in 1977.

As further evidence of government's growing interest in physician education, a bill calling for a CME relicensure requirement was introduced in the current legislative session.

Our House of Delegates voted to endorse the CME requirement (as an alternative to re-examination) provided: (1) ISMS plays a primary role in certifying the educational quality of CME programs; and (2) The requirement will not decrease the availability of physicians in communities and jeopardize medical care.

The emphasis on continuing education and the competence of physicians is understandable. Anything less then high quality medical care is expensive—expensive in dollars if physicians ineffectively prescribe costly remedies, and expensive in life and suffering if the powerful tools and techniques of contemporary medicine are used incorrectly or not at all.

Is it necessary to legislate continuing education requirements?

Statistics reveal that CME, because of expanding physician interest, has literally boomed in Illinois and throughout the nation in the last decade.

In 1961-62, there were 1,100 CME courses in the country. Today, there are almost 2,500. Ten years ago, 57,000 physicians were enrolled in such courses. Today, the figure is approaching 200,000.

I believe our support of ICCME and voluntary participation in continuing education clearly indicates we realize medicine is more than a learned profession—it is a learning one as well. ◄

William E. Screws M.D.

Unity + Strength = Effectiveness

Opinion & Dialogue

"Prescription drugs — who should determine the maker?"

Dispenser of Medicine

Clifton J. Latiolais
President
American Pharmaceutical Association



"Too many doctors are indifferent to the economic consequences of their decisions." So stated a recent issue of *Medical News Report* (December 4, 1972), an independent weekly newsletter published by former AMA Chief Executive F. J. L. Blasingame, M.D.

Doctor, are you indifferent...?

In discussing an anticipated increase in Blue Shield rates, Dr. Blasingame's newsletter had this to say:

"In general, it can be said, MD's have given the impression they are not particularly concerned with the increase in cost of health care to their patients...

"True, an MD's training is primarily scientific, but in the real world of practice, all of his scientific decisions have a price tag, or an economic impact. The economics of health care beckon the practitioner's attention. Concern for economics of medicine

Maker of Medicine

C. Joseph Stetler
President
Pharmaceutical Manufacturers Association



When the pharmacist recommends that a drug product other than the one ordered be dispensed, the prescriber invariably permits the change when he feels the best interests of the patient will be served.

Shortcomings of Pro-Substitution Argument

The fact remains that it is necessary for the prescriber to know that the change is being contemplated, and to be in a position to consent or demur. Without that opportunity, the unilateral decision of the pharmacist, made in the absence of clinical knowledge of the patient, could expose him to needless risks, and in addition, jeopardize the relationship between the professions of Pharmacy and Medicine. In my view, there is nothing in the pro-substitution argument that offsets these risks.

The Issue of Drug Knowledge

Substitution advocates claim that the primary justification for changing the rules is the desire to better utilize pharmacists' knowledge about drugs. Yet the pharmacist's task to keep current on the entire field of drug therapy, to some degree, puts him at a disadvantage. Most often, a practicing physician will need expert knowledge of no more than 25

Advertisement

Editorials



Patient's Bill of Rights

The 12-point "Patient's Bill of Rights" approved by the Board of Trustees of the American Hospital Association no longer is news, but we offer a synopsis as it appeared in the *Medical News Report* for those who may have missed it. Most hospitals have been practicing the contents of the Bill inasmuch as they cover the most commonly questioned situations encountered by patients in a hospital. The role of physicians also is spelled out:

The 12 points are:

1. Patient has right to considerate and respectful care.

2. Patient has right to complete, current information about diagnosis, treatment, and prognosis in terms he can reasonably be expected to understand and he has right to know by name the MD responsible for coordinating his care.

3. Patient has right to receive from an M.D. information necessary to give informed consent prior to start of any procedure or treatment and name of persons responsible for them.

4. Patient has right to refuse treatment to extent permitted by law and to be informed of medical consequences of his action.

5. Patient has right to every consideration of his privacy concerning his own medical care program.

6. Patient has right to expect all communications and records of his case will be treated as confidential.

7. Patient has right to expect that within its capacity, hospital will make reasonable response to his request for services.

8. Patient has right to information regarding any relationship of hospital and other health care and educational institutions that affect his care and professional relationship among individuals treating him.

9. Patient has right to be advised and right to refuse if hospital proposes to engage in or perform human experimentation affecting his care or treatment.

10. Patient has right to expect reasonable continuity of care, including care following discharge from hospital.

11. Patient has right to examine and receive explanation of his bill regardless of the source of payment.

12. Patient has right to know what hospital rules and regulations apply to his conduct as a patient.

The American Hospital Association recognizes that ". . . a personal relationship between the physician and the patient is essential for the provision of proper medical care. The traditional physician-patient relationship takes on a new dimension when care is rendered within an organizational structure. Legal precedent has established that the institution itself also has a responsibility to the patient." ◄

T. R. Van Dellen, M.D.
Editor

1. *Medical News Report*, 1973.

(Editorials continued on page 508)

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The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

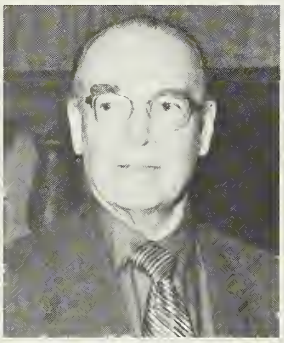
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Thomsen Elected To Head IFMC



Thomsen



Smith



Young



Bordenave

Philip G. Thomsen, M.D., has been elected President of the Illinois Foundation for Medical Care. Other officers included Vice President, **R. Glenn Smith, M.D.**; Secretary, **Francis Young, M.D.** and Treasurer, **Joseph L. Bordenave, M.D.** The Executive Committee of IFMC will consist of the new officers and **Robert J. Becker, M.D., Frank J. Jirka, Jr., M.D.** and **Eugene P. Johnson, M.D.**

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Description. Proloid (thyroglobulin) is obtained from a purified extract of frozen hog thyroid. It contains the known calorigenically active components, Sodium Levothyroxine (T_4) and Sodium Liothyronine (T_3). Proloid (thyroglobulin) conforms to the primary USP specifications for desiccated thyroid—for iodine based on chemical assay—and is also biologically assayed and standardized in animals.

Chromatographic analysis to standardize the Sodium Levothyroxine and Sodium Liothyronine content of Proloid (thyroglobulin) is routinely employed.

The ratio of T_4 and T_3 in Proloid (thyroglobulin is approximately 2.5 to 1.

Proloid (thyroglobulin) is stable when stored at usual room temperature.

Indications. Proloid (thyroglobulin) is thyroid replacement therapy for conditions of inadequate endogenous thyroid production: e.g., cretinism and myxedema. Replacement therapy will be effective only in manifestations of hypothyroidism.

In simple (nontoxic) goiter, Proloid (thyroglobulin) may be tried therapeutically, in nonemergency situations, in an attempt to reduce the size of such goiters.

Contraindication. Thyroid preparations are contraindicated in the presence of uncorrected adrenal insufficiency.

Warnings. Thyroglobulin should not be used in the presence of cardiovascular disease unless thyroid-replacement therapy is clearly indicated. If the latter exists, low doses should be instituted beginning at 0.5 to 1.0 grain (32 to 64 mg) and increased by the same amount in increments at two-week intervals. This demands careful clinical judgment.

Morphologic hypogonadism and nephroses should be ruled out before the drug is administered. If hypopituitarism is present, the adrenal deficiency must be corrected prior to starting the drug.

Myxedematous patients are very sensitive to thyroid and dosage should be started at a very low level and increased gradually.

Precaution. As with all thyroid preparations this drug will alter results of thyroid function tests.

Adverse Reactions. Overdosage or too rapid increase in dosage may result in signs and symptoms of hyperthyroidism, such as menstrual irregularities, nervousness, cardiac arrhythmias, and angina pectoris.

Dosage and Administration. Optimal dosage is usually determined by the patient's clinical response. Confirmatory tests include BMR, T_3 ^{131}I resin sponge uptake, T_3 ^{131}I red cell uptake, Thyro Binding Index (TBI), and Achilles Tendon Reflex Test. Clinical experience has shown that a normal PBI (3.5-8 mcg/100 ml) will be obtained in patients made clinically euthyroid when the content of T_4 and T_3 is adequate. Dosage should be started in small amounts and increased gradually with increments at intervals of one to two weeks. Usual maintenance dose is 0.5 to 3.0 grains (32 to 190 mg) daily.

Overdosage Symptoms. Headache, instability, nervousness, sweating, tachycardia, with unusual bowel motility. Angina pectoris or congestive heart failure may be induced or aggravated. Shock may develop. Massive overdosage may result in symptoms resembling thyroid storm. Chronic excessive dosage will produce the signs and symptoms of hyperthyroidism.

(Treatment: In shock, supportive measures should be utilized. Treatment of unrecognized adrenal insufficiency should be considered.)

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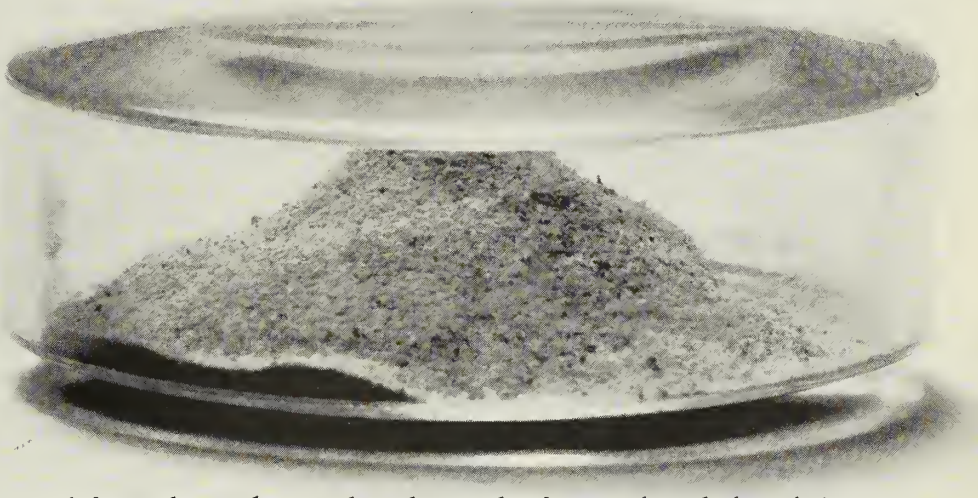
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(thyroglobulin)

natural thyroid therapy that leaves nothing to chance

Guest Editorial

Which are witch?

THE WITCH DOCTORS in Kenya have formed a national association that all practicing witch doctors, herbalists, palmists, and astrologers are being asked to join. About 5,000 witch doctors have been licensed by the government in Kenya; thus they have a sort of official medical status—and let the government know where they are and what they are doing. In the Swahili language the organization is called *Waganga Wa Mti Shamba.*

The members of peculiar medical cults, the purveyors of nostrums, the faith healers, and the leaders of strange sects have now and then formed similar associations in this country. The first step is usually to issue a news release calling attention to the evils perpetrated by the AMA, asserting that it is tyrannical, malicious, greedy, intolerant, and commercial. The AMA actually has no legal powers, no punitive powers, and no authority to stop anyone from practicing medicine of any kind, no matter how questionable its validity. It controls quackery and exploitation of the public only by a program of public education.

AMA investigators constantly determine the nature and scope of the ways in which the public is victimized and then publish the results of their investigations. Gradually, through the informed passage of restrictive legislation by the individual states and through the regulatory powers of such federal agencies as the FDA, Post Office Department, and the FTC, the purveyors of peculiar medicine disappear.

At present chiropractors flourish in some parts of the U.S., where they are licensed to manipulate the spinal column to relieve the pressure of misaligned bones on nerves, which they allege causes many ailments. Once in the field, however, some chiropractors, like a variety of other cultists, begin to treat their patients with physical therapy devices and sometimes even drugs. A recent change of regulations by the Social Security Administration permits chiropractors to diagnose and treat Medicare patients—provided however, that they confirm by x-ray the existence of the supposed lesion on the patient's spinal column and limit their treatment to physical manipulation of the tissues involved.

In most states, of course, chiropractors may not personally use the x-ray, so they must gain the cooperation of a competent radiologist. Further, scientific attempts to find the lesions claimed by chiropractors and to determine the extent to which they may be controlled by chiropractic adjustment have been uniformly negative. It remains impossible to separate the psychosomatic feeling of well-being associated with the "laying on of hands" by a chiropractor from the correction of the postulated physical abnormality of the spine.

The x-ray is one of the most important and versatile diagnostic discoveries ever made in medical science. By use of this technique, physicians have been able to detect changes in the cartilages that lie between the vertabrae. They have been able to verify the diagnosis of hiatus hernia, of the damage that affects the semilunar cartilages of the knee joint, a prime source of disability for football players, and many other pathologic conditions. But the use of the x-ray in a vast number of cases has failed to confirm the presumed anatomical disturbances that chiropractors allege to be the primary source of such conditions as headaches, asthma, emphysema, backache, kidney and gallbladder ailments, and even arrhythmias. Nor have chiropractors ever been able to explain why the bone, once pushed away from the nerve on which it is said to press, has to be pushed away again and again and again.

The government of Kenya has perhaps found that dealing with an association of witch doctors is an effective way of finding who the witch doctors are and the extent of their practices. Frequently the witch doctors steal away into the bush to carry on their arcane rites of healing. The leader of the witch doctors' association, Quama Makadudi, says that the witch doctors ought to be licensed so they may receive due respect for their essential public services. He could have left out the word "essential." ◄

Morris Fishbein, M.D.
Medical World News

VD An Equal Opportunity Destroyer

VD is short for the words venereal disease. *Untreated,* VD can also be short for the word "life." Venereal disease is the general name given to those communicable diseases caused by germs which are passed directly from person to person during sexual intercourse or by close body contact involving the sex organs, mouth or rectum.

Don't Ignore It

Closing one's eyes to the ever increasing problems of venereal diseases—especially gonorrhea and syphilis—will not make those problems go away. As a matter of fact, "closing one's eyes" to the *problems* of VD can cause blindness. VD is not one of your snobbish diseases. It can infect the rich and the poor, the black, the white, the red, the yellow. It has been found that white suburban teenagers have about the same VD problems as non-whites. VD doesn't care if one earns $2000 a year or $2 million a year, whether one is upper-crust or whether one doesn't know where the next piece of bread is coming from. It's a very social disease. It's not fussy about neighborhoods, either. It gets along just as well in the suburbs as it does in the inner city.

Some Important Facts

Because VD is the leading communicable disease problem in the United States and the most common of these venereal diseases are gonorrhea and syphilis, some basic facts are in order. Gonorrhea and syphilis are completely different, but the germs of *both* die almost immediately outside of the human body when exposed to light and air. Therefore, there is no danger of catching VD from toilet seats, drinking cups or eating utensils.

There is no immunity from either gonorrhea or syphilis.

Of the people who develop syphilis *and do not get treatment*

- 1 in 4 will die of a complication due to syphilis.
- 1 in 15 will become a syphilitic heart victim.
- 1 in 25 will be crippled or incapacitated.
- 1 in 50 will develop syphilitic insanity.
- 1 in 100 will become blind.

A pregnant woman who has syphilis may pass it through her blood to the placenta and then to her unborn child. The mother may have a miscarriage or the baby may be born dead. Should the child be born alive, it may be sickly, have sores and rashes or be deformed. On occasion the baby can be born with hidden syphilis which can result a few years later in the child's becoming blind, deaf, crippled or insane. In some cases the child doesn't live past its first few birthdays. The pregnant mother who has syphilis *and is not treated* has only 1 chance in 6 of having a healthy baby. Pretty lousy odds to present to an infant, isn't it?

Proper Treatment

Usually, it takes only a few shots of penicillin to cure either syphilis or gonorrhea (for those who can't tolerate penicillin there are other drugs available). It makes a person wonder why anyone would hesitate for a moment getting an examination and treatment either from his personal family physician or from one of the fine doctors at a VD clinic

Gonorrhea

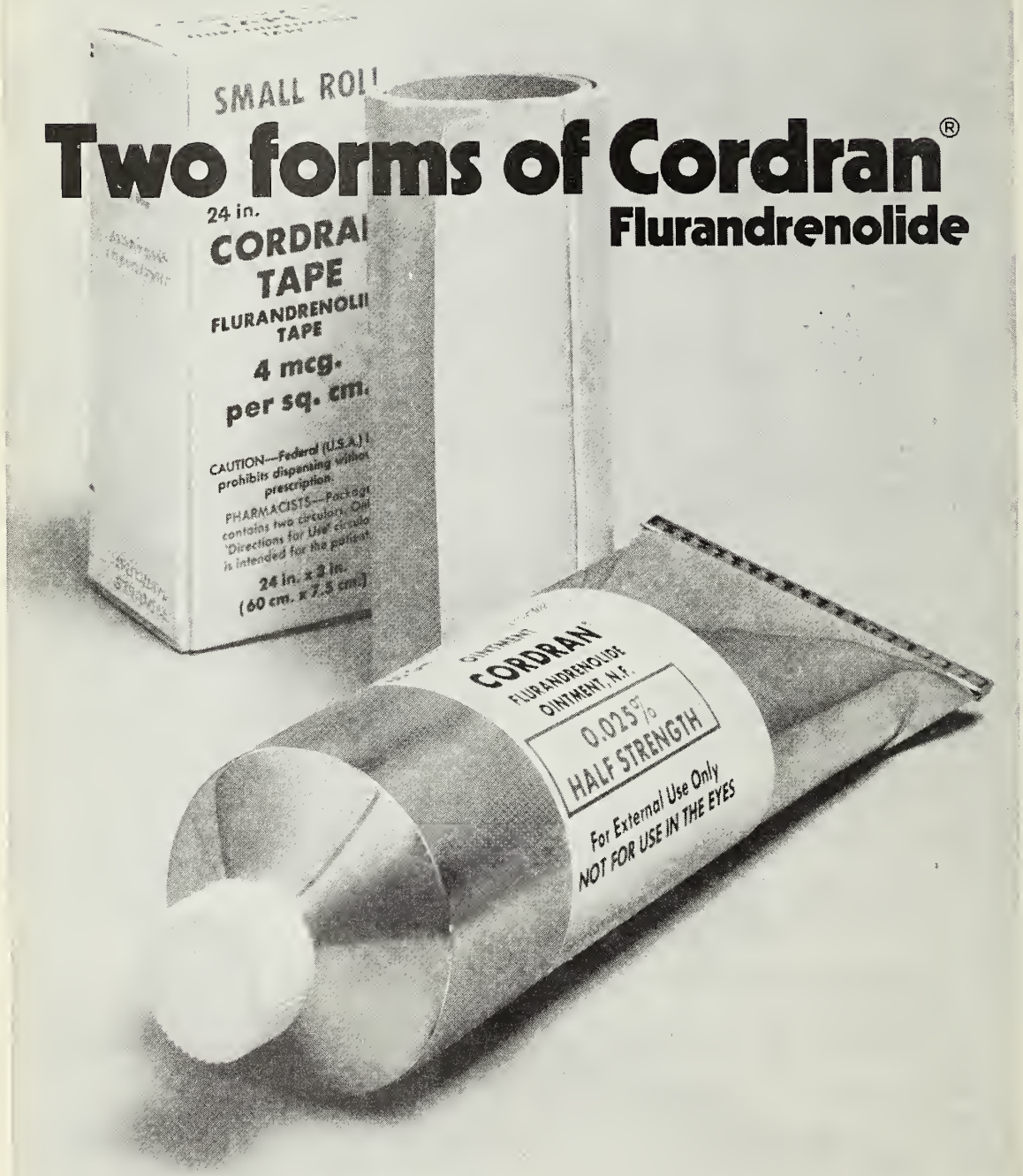
Gonorrhea hits young people more than any other age group; at least one in five persons with the disease is under 20. It has been estimated that this year alone there will be 2,500,000 *new* cases of gonorrhea. Although men and boys have gonorrhea symptoms from only three to five days after exposure to the disease, women and girls who get infected are not fortunate enough to get so early a warning. Consequently, by the time there are outward signs, the disease has progressed to the serious stage. Eventually, *if untreated,* the woman with gonorrhea can become sterile—and if the woman *is* able to have a child, it can be born blind. Since gonorrhea can be cured with penicillin and other antibiotics, a person's got to be a mental midget not to get help—and get it fast.

Read This

Here's good news. There *is* help. It's fast, it's free, it's confidential and minors *do not* need parental consent—nor are the parents notified. The Du Page County Health Department has a Social Hygiene and VD Clinic at 222 East Willow in Wheaton (Phone 668-7500) which is open Monday and Thursday from 3-7 p.m. and Saturday from 11-5 p.m. The phone service is 24 hours a day, seven days a week. To find the clinic closest to you phone (area code) 800-252-8989. This is the number of the "VD Checkline" and operates 24 hours a day. ◄

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IMJ
Illinois Medical Journal
Vol. 143, No. 6, June, 1973

Migrant Health Care — an Attempt to Meet the Problem

By Fred Z. White, M.D./Chillicothe

An innovative program for migrant health care was developed during the early months of 1972 by the Illinois Migrant Council, the Princeville Migrant Council, Region V of HEW, and the Family Practice Residency of the Peoria School of Medicine. This program was developed in response to the many needs of this unique population group. A pilot program that resulted from this discussion became operational in April of 1972.

Our Attempt to Meet the Problem:

The funding of migrant health care has been undergoing a change from the grant method of financing services to a prepaid capitation system. The precept of a prepaid capitation system was basic in the consideration of this program. Also accepted was the premise that health services for migrant populations should be reasonably comprehensive, should be accessible and available throughout the year and should include prevention and health maintenance services, as well as the necessary episodic or emergency care. Ideally the care received by migrants should be delivered in the same setting as is used for the usual more permanent population of an area. In addition, the only standard for care should be the highest quality of care available and that standard should prevail regardless of the population group(s) involved, so the services for migrant workers should not be isolated or separated from the rest of the community.

Ideally we felt that the health service should be community centered, and migrant families, as a temporary part of the community, should be served through the health service as is every other member of the community. These two prerequisites to a system of health care delivery do not, at least on the surface, appear very formidable as stated. A prepaid capitation health care system of good quality, available to all members of the community, offering comprehensive, preventive maintenance and emergency care should not be impossible to achieve. However, the unique characteristics of the migrant population that we are attempting to serve make this a little more difficult.



FRED Z. WHITE, JR., M.D., Chillicothe, is a Clinical Associate in Family Practice and Director of Graduate Education for Family Practice at Peoria School of Medicine. Dr. White, an ISMS Trustee, serves on numerous ISMS councils and committees and is a Diplomate of the American Board of Family Physicians.

This population migrates on an irregular track throughout the year. The migrating group changes in numbers of families as it moves. The same group does not necessarily always travel together. Therefore, the tracks are different and those families on identical tracks vary.

For the greater part of the year the families are at their homes in Texas (Hidalgo County for this pilot program) where health care services are at a minimum and available time for the migrants is at a maximum. During migration all family members attempt to work to supplement family income. While in the migrant stream, health care services are more available than in Texas, but migrant time availability is much less than in Texas.

The Family Practice Residency, upon which this project really depends, is a program of the Peoria School of Medicine located primarily at the Methodist Hospital in Peoria. Central to the thought of providing care for these very mobile and difficult-to track families is a record-keeping system. Our solution to this difficult problem is the Problem Oriented Record.

The Family Practice Residency Program, with backup from specialty staff, agreed for a 12 month experimental period to provide or otherwise assure the delivery of comprehensive health maintenance and treatment services (including in-hospital care) to an enrolled group of approximately 20 migrant families (agreement based on 120 people enrolled in family group), who come from Hidalgo County, Tex., to pick and process crops in the environs of Princeville. Since it was assumed that the enrollees would be away from the Princeville environs six to nine months of the 12 month period, the Family Practice Residency Program recognized a necessity to maintain professional liaison with the Hidalgo Migrant Facility and other medical groups caring for these enrollees. There was also a recognized need to maintain some kind of control over the plans developed for each patient and a need for a "medical audit" to assure appropriate utilization of medical resources away from Princeville. The Family Practice Residency Program contracted for this service (and in turn assumed responsibility for reimbursing providers who served the enrollees in Hidalgo County or elsewhere in the course of their migration) at $200 per enrollee or approximately $24,000.

It was the intent of the program to do a complete base-line examination on each member of this group. With the Problem Oriented Record System, a problem list was developed on which all of the patient's problems were listed as they were identified. Reference was then made to each problem under consideration on the progress and notes as the patient was seen, and immediate future treatment plans were indicated. With this system, it was hoped that continuing care could be maintained even in a population as mobile as this.

The purpose of the project was to test the hypothesis that continuing comprehensive care could be rendered to mobile family groups such as migrant families, through a cooperating group of health care delivery facilities working with the Problem Oriented Record.

Problem, Problems!

Conceptually the proposal appeared sound, and the plan for implementation of the proposal was feasible. In actuality, however, it became apparent quite early that all was not going according to the pre-game plan. Furthermore, as data continued to accumulate through the project year, that which was apparent in the beginning developed into the hard fact that the implementation of this project had not followed the presupposed pattern.

Retrospective consideration of this initial year led to the conclusion that almost all of the possible mistakes in implementation had been made in this attempt. From this retrospective evaluation several conclusions were drawn:

1. Initial attempt towards a solution of this huge societal problem was minimally effective as an attack of the problem. However, as an experience in learning on how to better approach the migrant health problem, this year could have real value.

2. The relative futility of this expenditure of one year of effort, when considered against the enormity of the problem and the equally minimal gains of past efforts could be considered a worthwhile investment *only* if proper utilization is made of this investment.

3. Effort must be directed towards developing a better plan and methods for improving the system that will deliver the ideal care and maintenance.

4. The equally important obligation that was felt was to make our experience available to others so that repeated missteps need not be taken. This crystallization of the experience of the first year, the internal critique of that year, and the plan and system with which the second year will begin, is offered in the hope that others working to develop better systems of health care delivery may find something of value.

Problem Areas During the Initial Year

Selection of plan participants was on a random and arbitrary basis. The names of family members migrating from Hidalgo County to the project base at Princeville were listed and the first 120 names on this list were designated as enrollees. These individuals were notified that as enrollees of this special plan they would have their health care needs taken care of for this year, and they were asked to come into the Center for a health evaluation and examination.

It then developed that some of the designated enrollees changed their plans enroute and never arrived at the project base. Several, for a variety of reasons, opted to seek care in their usual manner, as they had in the past. A significant number never came in for this initial evaluation simply because they preferred not to take time from productive work in the field.

As a result, not all members of totally enrolled families were examined, and yet the project became responsible for their care for the year. Others moved on to other locations without evaluation of any of the family members, expecting continued care throughout the year to be charged, like an open-ended credit card, to the project. Finally, most of the enrollees took advantage of the good weather to work, and with this good weather, the harvest was shortened. The result was a patient overload at the end of the stay in Princeville, so that complete treatment plans could not be properly developed and instituted for these many latecomers.

Next was the problem of record transmission. The plan was to send the records, with the data base, and treatment and health maintenance plans, to the next stop ahead of the participants. It was anticipated that the next migrant care facility could then review the records and be ready for our enrollees when they arrived.

Contrary to the plan, however, the entire group did not travel to the next stop as a unit. With departure time imminent, it became apparent that several different destinations were planned. Records were rearranged for transmission and given to members who seemed to be leaders of these sub-groups. Again, plans were changed enroute depending on information that came to the migrants regarding availability of work on the track ahead. The result was that records and families went their separate ways, and in some cases, "never the twain to meet."

A final and very serious problem area was that of evaluation. Retrospective evaluation was almost impossible, other than the painfully apparent conclusion that very little went as planned.

Second year improvements were made as a result of this experience resulting in the following changes in the system.

Enrollment

Present members of the plan and others from Hidalgo County who will be migrating to Princeville this year were sought out in Texas, and the benefits of the plan, as well as the enrollees' obligations were explained by a Spanish speaking medical social worker and his staff. Enrollment, however, will not become a fact until the individual agrees to the provisions of the plan and presents at the project base in Princeville for the base line health evaluation and examination. Then as an enrolled member, a treatment and health maintenance plan is constructed for him/her. The permanent record of each enrollee is maintained at the project base, while a copy of this record is given to the head of the family for each family member. These records will travel with the family through the course of its migration.

Goals and Objectives For the Program

These have been drawn up, and evaluation will be made currently and retrospectively, on how closely these goals are realized. An instrument has been developed in an attempt to assess continuing care away from the project base, while adding data to the patient's record. It will also act as an evaluation instrument, since it will indicate whether or not specific treatment goals are met. This paper will indicate the patient's problem with the plan for future care, i.e., examination, procedure, lab test, etc., as well as the interval at which this is to be performed. The patient is to present this form, with his record, to the care facility nearest to him at the indicated time. This facility will then perform the required procedure, note the findings on the form (and on the patient record), indicate the fee for this service and return the form. At the project base, the information will be entered into the permanent record, and the fee will be paid to the provider of the service. If an adjustment in the treatment plan is to be made, this can be done by the "up-stream provider" or the project base can notify the enrollee directly.

Through this means, we will be able to evaluate the compliance of the patient as well as the "up-stream" system. It will also allow an ongoing and current evaluation of that individual patient's specific problem.

Goal:

To develop a system of health care delivery for migrant families that is appropriately comprehensive, and achieves the same continuity of care as is provided in the usual manner for non-migrating families.

Objectives:

1. **Standard of care should be of highest possible quality.**
 A. Establish a predetermined data base that is appropriate for this population according to age and sex.
2. **Evaluate health status of each enrollee.**
 A. Examine each family member on entrance into the program to establish individual data base and identify any existing problems.
3. **Initiate and continue programs or plans to insure continuing health through preventive measures for any problems for which this population would be at risk.**
 A. Bring immunization status to proper current level for age of patient. Electively correct any identified problems and/or deficiencies.
4. **Develop treatment plan for any problems that will require continuing care or monitoring.**
 A. Begin treatment, and attempt to get to optimum or most stable level before leaving program base.
5. **Develop and propagate a system and appropriate records to assure that plans for continued maintenance of health; monitoring and treatment will be followed by other providers.**
 A. Prepare record summary and health maintenance or care plan.
 B. Effectively monitor identified problems consistent with treatment plan.
 C. Identified deficiencies earmarked for "upstream" correction should be corrected.
 D. Treatment and monitoring plans should be continued as directed by "upstream" providers.
 E. Allow other providers to respond to new problems that may develop "upstream" from project base, i.e., diagnostic W. U., initiate treatment and prescribe plan for continuity of care.
6. **Record system must be flexible and useable (acceptable).**
 A. The record system and plans should be understandable to the "upstream" providers.
 B. Additions to the record, progress notes, etc., should have entry to the record system.
 C. All additional entries should eventually be incorporated into the complete "base" record.
7. **This system of care should be acceptable to the enrollees.**
 A. Expenditures by the enrolled patients, in terms of time, discomfort, effort, time away from job, etc., should be same as for a non-migrating population.
8. **Keep costs at lowest level consistent with the highest quality of care.**
 A. Prevent excessive and/or unnecessary duplication of laboratory tests.
 B. Maintain continuity of treatment with consistent plan of treatment and elimination of excessive drug costs due to changes of medicines, etc.

Summary

An approach to the monumental problem of migrant health care has been described. Pitfalls encountered during the initial year of experimethods to improve have been outlined. It is hoped that lessons learned through mistakes this system in its second year have been outlined. It is hoped that lessons learned through mistakes made during this first year will be of value in preventing like missteps for other groups working in these difficult areas of health care delivery. Central to this particular approach to the migrant health problem is the concept that the Problem Oriented Record is an ideal vehicle for the delivery of care and the maintenance of health of this group of migrants. Evaluation of the system as well as the validity of the concept will be attempted in an ongoing and current manner, as well as retrospectively. The predetermined criteria suggested for this evaluation are the objective goals for the program, for the system, and for the care and maintenance of the individual patients. The underlying hope is that the experiences gained here, and in other similar efforts, will help to develop a health care delivery system that can successfully meet the needs of these uniquely mobile American families. ◄

Editor's Note: At the ISMS Annual Meeting held in May 1973, the following resolution was passed by the House of Delegates:

RESOLVED, that the Illinois State Medical Society House of Delegates urge the American Medical Association to make every effort to obtain federal and/or other funds to establish a health care training program for migrant workers; and be it further

RESOLVED, that the program be developed by the American Medical Association through its committee on Health Care of the Poor for the special training of migrant health care volunteers who themselves would be members of migrant families. These migrant volunteers would: travel along the migratory stream and function as health advocates for all migrants; offer temporary care to migrants until more definite care could be found; direct families to existing medical facilities; interpret the needs of the people to the medical community; extend prescribed care to families as they move; and be it further

RESOLVED, that health program planners take into consideration that the only time available to migrant workers for a health care training program is while they are at their more or less permanent homes in Texas or other southwestern or southern states, rather than during the busy season in other areas where they must work long hours to earn all they can.

National Cooperative Study of Hepatitis B Antibody Treatment of Antigen-Positive Fulminant Hepatitis: First Randomized Case in Illinois

By Bernard F. Clowdus, M.D., F.A.C.P.,* Frederick Steigmann, M.D., F.A.C.P., Sudin Vittal, M.D., and Demetrios Dourourekas, M.D./Chicago

The authors present a resumé of the circumstances surrounding the recovery of a patient with fulminant type B viral hepatitis. The patient represented the **first case in Illinois** to be randomized within the cooperative study of the National Institutes of Health and the 33rd in the nation to be afforded the possibility of receiving hepatitis B immune globulin as treatment.



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Immunotherapy of fulminant type B viral hepatitis with specific antibody has been made feasible by recently developed laboratory tests. The efficacy and the safety of this form of treatment, however, are unknown. Gocke *(New Eng. J. Med. 284:919, 1971)* observed a trend toward benefit in a very limited number of patients, but interrupted this uncontrolled trial in recognition of the fact that a cooperative study would be necessary. A few other published and unpublished instances of use in scattered cases are known, but these are also inconclusive. On the other hand, potentially harmful effects have been suggested on a theoretical basis, but whether they are related to this form of therapy or underlying disease can only be documented by careful study and comparison with cases not so treated.

Because adequate evidence must be obtained to justify uncontrolled use of material in a very limited supply, a nationwide trial has been instituted under auspices of the National Heart and Lung Institute. This double-blind comparison is between a high titer hepatitis B immune globulin and an albumen placebo. All due safeguards to protect the patient have been undertaken, as well as measures to stop the trial immediately if: (1) it becomes apparent that the hepatitis B immune globulin is effective; or (2) adverse reactions make worse the already poor prognosis (estimated survival is 10% to 20%) of patients with fulminant type B viral hepatitis.

Case Report

This 22-year-old white female registered nurse,

in the dialysis unit of Rockford Memorial Hospital, was pricked by a needle used on a dialysis patient positive for Australia antigen. No gamma globulin was given. She was well until April 4, 1973, when she developed a sore throat and malaise. This soon was accompanied by nausea. There was no past history of blood transfusion or parenteral drug administration. She had been taking birth control pills, but no other drugs. Her husband is an M.D. (intern) and they have been married for 5 months.

April 8, 1973 — First noted to be jaundiced. Total serum bilirubin 11.5, SGOT 4980, SGPT 7250.

April 9, 1973 (11 A.M.) — Admitted to Rockford Memorial Hospital. Examination showed a confused, jaundiced, young female. BP 120/80, P 80/min. Mild tenderness over the right upper abdomen. No hepatosplenomegaly, ascites or asterixis. She was only intermittently oriented as to time, place and person. Total serum bilirubin 9.7. Prothrombin time 12% of normal. HBAg positive by counter immunoelectrophoresis (C.E.P.) Her mental status deteriorated over the next 8 hours. Asterixis appeared. No medication was given.

April 9, 1973 (11 P.M.) — The Chicago Hepatitis Coordinating Center, Hektoen Institute for Medical Research, was contacted and arrangements were made for the patient to be transferred to Edgewater Hospital, Chicago, for further management.

April 10, 1973 (3 A.M.) — Patient arrived at Edgewater Hospital. Physical examination revealed an obtunded, jaundiced, young female in Stage IV hepatic coma. Occasionally she would scream or become restless for only a minute and then would again lapse into unconsciousness. The deep tendon reflexes were exaggerated. Asterixis was absent. Plantar reflexes were flexor. BUN 0, Glucose 110 (10% glucose infusion I.V. running). Serum electrolytes: Na=141, K=3.6, CL=107, pH=7.51. Prothrombin time 16% of normal. There was transient blood-tinged urine flowing through the catheter. HBAg positive, HBAb negative by C.E.P.

April 10, 1973 (5 A.M.) — The National Coordinating Center was contacted and code numbers were given to the Chicago Center by computer designating those unidentified bottles of human serum protein which were to be given to the patient. Infusion was started at 5:15 A.M. and given over the next 70 minutes without any immediate or later adverse effects. General condition of the patient remained the same.

April 10, 1973 (5 P.M.) (12 hrs. post-infusion) — Her general condition was about the same; however, one nurse who had been caring for her all day reported that she was becoming lighter. Asterix absent. Urine clear. No hemorrhagic manifestations present.
Tests done at 3 P.M. showed: Pro. time 17% of normal; Serum Na=140, K=3.3, Cl=106, pH=7.48, fibrinogen=140, platelets=160,000. HBAg-positive by C.E.P.

April 11, 1973 (8 A.M.) (27 hrs. post-infusion) — Patient still in Stage III-IV coma, but now very slightly responds to verbal stimuli by opening the eyes. She was still jaundiced. There were no hemorrhagic manifestations. Urine continued to be clear. No hepatosplenomegaly or ascites. Mild asterixis present this morning. Temp. normal. BP 120/80. Pulse 110/min. Reg. Well hydrated. Urine output in 24 hours: 3500 ml. Serum electrolytes: Na=143, K=3.3, Cl=109, fibrogen 120,

BUN=0, Pro. time 21% of normal. HBAg=positive by C.E.P. and Radio-immunoassay (R.I.A.) and the titre is falling.

April 12, 1973
(8 A.M.)
(39 hrs. post-infusion)

Patient had shown remarkable improvement. She was now conscious, oriented to place, time and person. There were no pathological neurological signs. No asterixis. Vital signs: normal. Good intake and output. Continued to be on no protein, only carbohydrate and I.V. fluids. BUN=2, Serum Na=142, K=4.1, Cl=111, pH=7.39, CO_2=25%, HBAg=positive by R.I.A., but titre had fallen further. Pro. time 32% of normal, total serum protein 6.5, albumin 3.4, total serum bilirubin 10, SGOT 250. She was allowed to take ice chips by mouth.

April 13, 1973
(8 A.M.)
(63 hrs. post-infusion)

She continued to make progress. Her consciousness was very clear. She was able to recognize all the doctors seen the previous day. The icterus appeared to be the same as yesterday. No pathological signs of the nervous system. No asterixis. Skin normal, except for mild thrombophlebitis in the I.V. area over right arm. Vital signs normal.
Serum electrolytes: Na=140, K=4.2, Cl=108, pH=7.44, CO_2=25%, Pro. time=39% of normal, SGOT=170. HBAg=positive. She was started on oral fluids.

April 14, 1973
(8 A.M.)
(87 hrs. post-infusion)

Much better today. Less icteric. Well hydrated. Tolerating oral intake well. No asterixis. Good intake and output.
Serum electrolytes: Na=131, K=4.1, Cl=109, pH=7.41, CO_2=24%. Pro. time=39% of normal, Glucose=120, BUN=3, total serum protein=6.2, albumin=3.25, total serum bilirubin=11, SGOT=135. She was started on protein-free carbohydrate diet.

April 15, 1973
(8 A.M.)
(111 hrs. post-infusion)

Continued to make progress. Catheter removed. Tolerating solid foods well. No pathological signs on physical examination, except for icterus. Prothrombin time 56% of normal. HBAg=positive. The titre was staying the same.

April 16, 1973
(8 A.M.)
(135 hrs. post-infusion)

Much less icteric. Well hydrated. Very cheerful. Has no urinary symptoms. Pro. time 65% of normal. SGOT=100, serum bilirubin=10, BUN=5, total serum Protein=6.3, Albumin=3.1. HBAg=positive by R.I.A. The titre is same as yesterday.

April 17, 1973
(8 A.M.)
(159 hrs. post-infusion)

Getting better every day. Mildly icteric. The I.V. line was now taken out. HBAg=positive by R.I.A., but the titre is considerably less than yesterday.

April 18, 1973
(8 A.M.)
(183 hrs, post-infusion)

Appeared less icteric. Tolerating oral intake well. Pro time 77% of normal. SGOT=100, Platelets =150,000. Fibrinogen=400.

April 19, 1973
(8 A.M.)
(207 hrs. post-infusion)

Percutaneous liver biopsy was done. Patient tolerated the procedure well. No immediate or delayed complications. Biopsy

showed features of acute viral hepatitis. SGOT=83.

April 20, 1973
(8 A.M.)
(231 hrs. post-infusion)
Doing well.

April 21, 1973
(8 A.M.)
(255 hrs. post-infusion)
Doing well. Total serum bilirubin=8.5, SGOT=75, BUN=9, Total Protein=7.2, Albumin=3.9.

April 22, 1973
(8 A.M.)
(279 hrs. post-infusion)
Doing well. Less icteric.

April 23, 1973
(8 A.M.)
(303 hrs. post-infusion)
Doing well. HBAg=Negative by C.E.P., but positive by R.I.A.

April 24, 1973
(8 A.M.)
(327 hrs. post-infusion)
Doing well.

April 25, 1973
(8 A.M.)
(351 hrs. post-infusion)
Doing well. Much less icteric.

April 26, 1973
(8 A.M.)
(375 hrs. post-infusion)
Ambulatory in room. SGOT=65, total serum bilirubin=3.7. HBAg=Negative by C.E.P., faintly positive by R.I.A.

May 3, 1973
(8 A.M.)
(543 hrs. post-infusion)
Patient discharged home. SGOT=35, total serum bilirubin=1.2. HBAg=Negative by C.E.P., negative by R.I.A.

Discussion

On April 18, 1973, the results of additional laboratory data obtained from analysis of serial post-infusion specimens of the patient's blood were first known. Antibody against HBAg had been detected in the patient's serum on the first post-infusion day, having been undetectable in pre-infusion specimens. The source for this antibody remains conjectural. It has been established that endogenous antibody production against the infectious agent occurs in many patients following exposure to HBAg containing material, and the detectability of HBAg will show temporal variation on both technical and bio-immunological grounds.

The data surrounding this patient are, therefore, far from conclusive and do not permit any basis for a generalization as to the cause for her recovery.

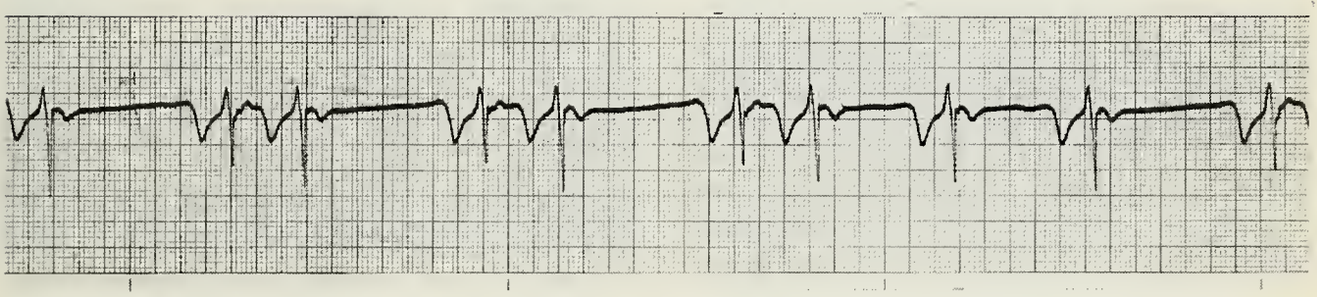
Continued effort must now be made to obtain further experience under controlled randomized conditions with the response of additional patients to immunotherapy. Any patient to whom the physician and the patient's family wish to offer the possibility of receiving hepatitis immune B globulin should be made known to the Hepatitis Coordinating Center of the Hektoen Institute for Medical Research, 627 South Wood Street, Chicago, 60612; telephone: (312) 633-7214; or contact either Bernard F. Clowdus, M.D. at (312) 878-6000 (24-hr. ans. service) or Frederick Steigmann, M.D. at (312) 346-2320 (24-hr. ans. service).

Criteria for eligibility include: (1) informed consent by relative; (2) a positive test for hepatitis B antigen (hepatitis-associated antigen, Australia antigen); (3) a prothrombin time prolonged 50% or more above the control; (4) stage II (a flapping tremor definitely present) or deeper coma; and (5) that no other therapy of doubtful or unknown benefit has been or will be applied (e.g. exchange transfusion, extracorporeal perfusion, or cross-circulation).

The chances for benefit from hepatitis B immune globulin are probably enhanced if it is given as early as possible after the onset of encephalopathy. Treatment of the patient in the control trial will be facilitated if you contact the Hepatitis Coordinating Center or either of the physicians listed above concerning patients already exhibiting drowsiness and having a significantly prolonged prothrombin time. ◄

ekg of the month

John R. Tobin, M.D., M.S., Rimgaudas, Nemickas, M.D., Patrick J. Scanlon, M.D., John F. Moran, M.S., M.D., James V. Talano, M.D., Sarah Johnson, M.D. and Rolf M. Gunnar, M.D., M.S./Section of Cardiology, Loyola University Stritch School of Medicine



A 56-year-old male was noted to have an irregular pulse by the nurse. This Lead II ECG rhythm strip was taken.

Questions:

1. The ECG rhythm strip demonstrates:

(a) Ventricular Bigeminy
(b) Marked Sinus Arrhythmia
(c) Atrial Premature Beats
(d) Junctional Premature Beats
(e) None of the above

2. Relative to this tracing, which of the following statements are true:

(a) The premature beats are followed by a fully compensatory pause.

(b) After the premature beats, the sinus node is reset so that the pause is less than fully compensatory.

(c) The different configuration of the premature beat is due to its origin from an ectopic focus in the ventricle.

(d) The different configuration of the premature beat is due to aberrant intraventricular conduction because of its prematurity.

(Answers on page 544)

Ectopic Hydroureter

By George B. Perlstein, M.D., Irving Weissman, M.D., and
Robert Pace, M.D./Champaign-Urbana

Instances of ectopic ureteral terminations have been reported by many authors.[1-5] **In none of the cases presented has the ureter attained the size observed in the patient herein reported.**

Case Report

On October 1, 1968, a 26-year-old man was admitted to McKinley Hospital, Urbana, because of acute onset of right lower quadrant abdominal pain. Hypertension of 170/120 was found. One month earlier, blood pressure elevation to 170/120 was found during the course of a physical examination given elsewhere prior to the patient's enrollment at the University of Illinois. In 1959, there was evidence that the blood pressure had been 126/80. Excretory urography performed in August of 1968, was said to have shown no function on the right side.

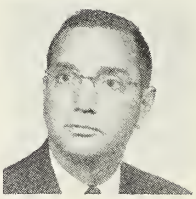
Positive findings on physical examination on October 1 revealed a patient who appeared moderately ill, complaining of pain in the right lower quadrant of the abdomen. Temperature was 98.6, the blood pressure was 160/110 in both arms both in the supine and sitting positions, the pulse was 70. The ocular fundi showed flame shaped hemorrhages at the periphery of the temporal vasculature on the left, and silver wiring on the right. There was no papilledema. Moderate tenderness was elicited over the right hypochondrium with a suggestion of a mass being present in the area. There was no rebound tenderness and the bowel tones were normal.

Laboratory studies: urine—specific gravity 1.004, trace albumin, pH 6.5, no sugar, 0-1 wbc/hpf, no red cells, casts, crystals or bacteria noted. Hemogram was within normal limits, SMA 12/60 determination was essentially within normal limits with the exception of an elevation of the blood urea nitrogen to 37 mg.%, serum creatinine 3.2 mg.%, and serum albumin 3.2 gm.%. Excretory urogram (Fig. 1) showed hydronephrosis and delayed function on the left side. There was lateral deviation of the ureter with lateral and downward displacement of the superior pole of the left kidney. There was no evidence of function on the right side over a three hour period of observation. Renal scan using 100 millicuries of Chloromerodrin showed no uptake over the right side either in normal or in pelvic location with uniform uptake on the left. Translumbar aortography demonstrated no right renal vasculature. The vasculature on the left appeared normal.

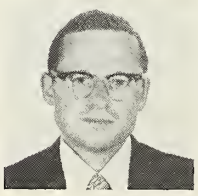
At cystoscopy, the trigone and floor of the urinary bladder were elevated by a cystic mass which could be ballotted through the rectum.



GEORGE PERLSTEIN, M.D., maintains a private practice of urology and is on the attending staffs of Burnham City Hospital and Mercy Hospital, Champaign-Urbana. He is a consulting urologist to McKinley Hospital. Dr. Perlstein is a Diplomate of the American Board of Urology and a Fellow of the American College of Surgeons.



IRVING WEISSMAN, M.D., is Radiologist-in-Charge at Mercy Hospital, Urbana. Dr. Weissman maintains a private practice in radiology and is consulting radiology at McKinley Hospital, Urbana. He is a Diplomate of the American Board of Radiology and Fellow of the American College of Radiology.



ROBERT L. PACE, M.D., is the Director of Clinical Medicine of the Student Health Service, University of Illinois, Urbana. A nephrologist, Dr. Pace received his medical degree from Wayne State University.

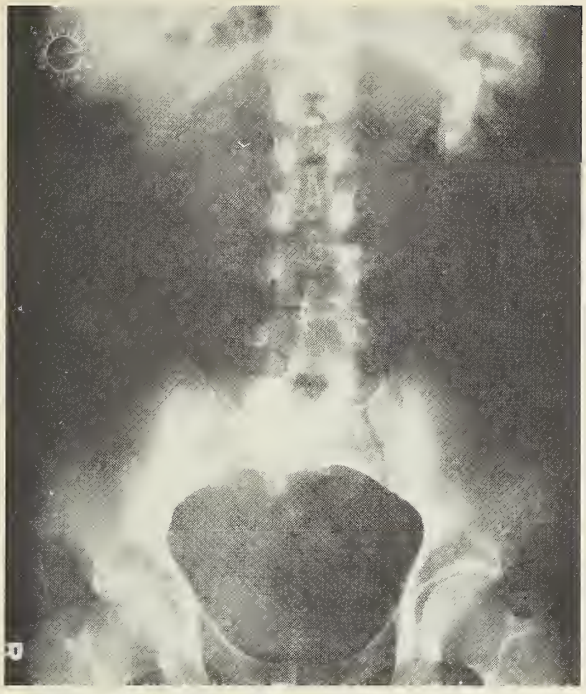


Figure 1. Excretory urogram.



Figure 2. Combined ectopic ureterogram, left (inferior) retrograde pyelogram with retroperitoneal gas insufflation.

No right ureteral orifice was seen and the bladder appeared huge. Left retrograde ureteropyelograms confirmed the findings noted on excretory films. No abnormalities of the urethra were noted on urethroscopy.

An 18 gauge needle was introduced via the perineum into the mass between the bladder and rectum. 450 cc. of straw colored fluid with a specific gravity of 1.002 was aspirated; 200 cc. of 50%Hypaque was then injected. The patient was then placed in the prone jack knife position and carbon dioxide was insufflated via a presacral needle. Contrast was injected into the inlying ureteral catheter and an X-ray was exposed (Fig. 2).



Figure 3. Appearance of ectopic ureter at laparotomy.

On October 9 a laparotomy was performed. A vesical diverticulum without a true neck extended up to the hepatic flexure of the large intestine. The huge dilated ureter originated from the superior portion of a duplicated left kidney which was represented by a thin margin of parenchyma. This ureter terminated after a devious course in the area of the prostatic apex. As a consequence of the compression by the ectopic ureter, the ureter draining the better, lower, segment of the left kidney had been partially obstructed sufficient to create moderately far advanced hydronephrosis.

The excess bladder was excised. The ectopic ureter (Fig. 3) was dissected free, preserving the thin renal parenchymal rim by creating a pyelo-pyelostomy between the upper and lower renal segments. The content of the ectopic ureter was found to be 2000 cc. of clear yellow fluid with a specific gravity of 1.004.

Subsequently, the patient's blood pressure has been maintained at 140-160/86-102 with the use of a low protein diet and Serpasil 0.25 mg. daily. His blood urea nitrogen on March 21, 1970, was

(Continued on page 544)

surgical grand rounds

Edited By John M. Beal, M.D.

Ruptured Spleen

Surgical Grand Rounds are held weekly on Tuesday at 5:00 P.M. in the Offield Auditorium at Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial and the Veterans Administration Research Hospitals form the basis of the discussions. This case report was part of the Surgical Grand Rounds of January 25, 1972.

Case Report

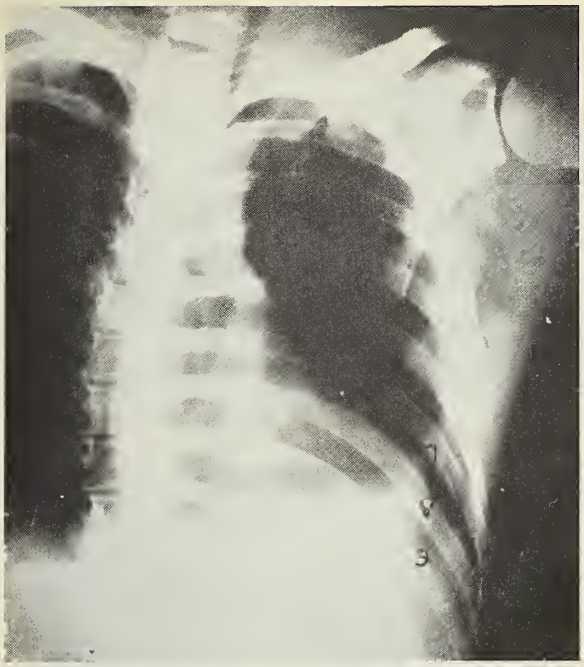
Dr. E. J. Smith: A 26-year-old white man was changing a light bulb while standing on cinder blocks. The upper most cinder block broke in half and he fell, striking his left thorax against the remaining cinder block. He was brought to the hospital where he complained of left chest pain. Physical examination in the emergency room revealed a mild tachycardia. There was an abrasion of the skin of the left lateral chest wall just about below the nipple. The auscultation of the chest disclosed a cracking sound over the left thorax. The abdomen was flat but there was diffuse tenderness and guarding in the left upper quadrant. Rectal examination was unremarkable.

The admission hematocrit was 45% and white blood cell count was 11,900. Urinalysis was negative. Roentgenograms of the abdomen and chest were obtained. The chest films demonstrated fractures of the left 5th, 7th, and 8th ribs, (Figure 1). The abdominal films were unremarkable.

When he returned to the emergency room from the X-ray department, a second blood count was obtained, approximately an hour and a half after admission. The second count showed a hematocrit of 45%, but the white count was now 19,500. A plastic tube was inserted into the abdomen, in the midline just below the umbilicus and a liter of normal saline was instilled. The patient was turned from side to side and a small amount of the fluid was removed which was found to be grossly bloody. The patient's vital signs remained normal. He was taken to the operating room where a midline incision was made. A substantial number of blood clots were removed and a substantial rent almost bisected the spleen. Splenectomy was performed. One unit of whole blood was given in the operating room in addition to supplemental electrolyte solutions. Postoperatively, a chest film was obtained. A small pneumothorax was found but did not require aspiration. The patient made an unremarkable recovery.

Dr. Philip Barney: Pathologic examination demonstrated the obvious rent in the spleen. Microscopic study showed that there was an acute neutrophilic excitation along the edge of the rent showing that this had been present for a matter of hours. The spleen itself appeared histologically normal.

Dr. Larry Monn: The mortality rate with rupture of the spleen is unusually high. This is due most often to associated injuries that occur in people who rupture their spleen and to the fact that people with multiple injuries have their splenic damage overlooked so that the diagnosis is not considered. The mortality rate in simple rupture of the spleen without associated trauma should be low. Splenic rupture may result from either penetrating or blunt trauma. As men-



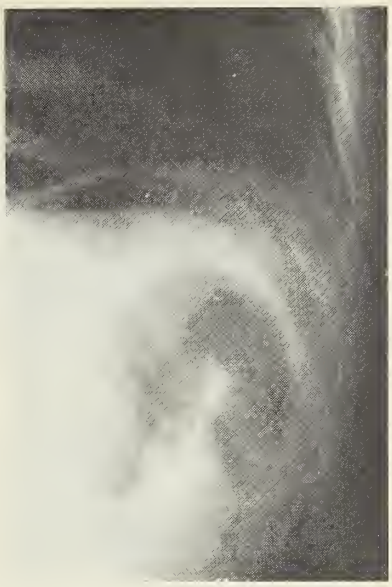


Figure 1-A. Chest X-ray showed fracture of seventh to ninth ribs.
Figure 1-B. Fractures of ribs are visualized better with spot films on lower rib cage.

tioned, patients may have a ruptured spleen in association with multiple severe injuries, such as a crushed chest, extremity injuries, and even central nervous system injury. The possibility of splenic rupture must be considered in any penetrating injury to the abdomen or chest regardless of it's location if it was produced by a missile. Blunt trauma to the abdomen or chest, even though slight, should suggest to the examiner the possibility of a ruptured spleen, particularly if the left side of the lower chest or upper abdomen is involved.

The management of acute injury to the spleen is that which one would give to any seriously injured patient on arrival in the emergency room. First, he must be resuscitated. For the novice examiner, it must be emphasized that the patient should be completely disrobed and examined for associated injuries. In addition to basic laboratory information, blood should be drawn for typing and cross-matching. Chest and abdominal X-ray films may be obtained but are not essential in patients who have ruptured spleens. However, when other injuries are suspected, X-ray examination is desirable. The patient should not be moved until vital signs are stable. Prior to transfer to the X-ray Department, we have found it advantageous to inject 30 cc of Hypaque intravenously. When the abdomen films are obtained, you gain additional information concerning possible associated kidney damage and whether the patient has two kidneys in the event that one of them has to be removed.

The majority of patients with penetrating trauma from missiles must be subjected to exploratory laparotomy. One may elect to follow a conservative course in patients with stab wounds; however, it is imperative that these patients be observed frequently and that they be checked by the same observer. The decision is much more difficult in the patient with blunt trauma. The patient who is deteriorating, although receiving apparently adequate replacement therapy and without other known source of injury to cause shock, should be explored. Left upper quadrant pain with guarding or rebound tenderness is a finding suggestive of splenic damage. Splinting of the upper abdomen, especially on the left side, unilateral guarding or decreased costal flare on breathing are also suggested.

The hemoglobin and hematocrit levels are of little value on the patient with an acutely injured spleen. The white count, however, is helpful. In one large series of patients, a white

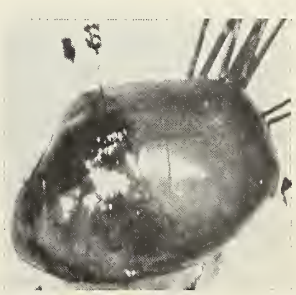


Figure 2. Subcapsular hematoma is demonstrated in spleen which was removed after stab wound.

count over 15,000 in a patient with blunt trauma of the abdomen, was associated with a ruptured spleen more than 95% of the time. This reliable sign was demonstrated in our patient. The abdominal tap is a useful item when properly interpreted. Recently we had a patient in whom we performed this procedure. He had a ruptured spleen and the tap was negative. Therefore, if an abdominal tap is positive it is helpful, but a negative tap does not exclude splenic injury.

Delayed rupture of the spleen will occur within the first 12 days of the injury in 75% and the peak is from 7 to 10 days after the injury. The lowest death rate, oddly enough, occurs in this group and is probably because these people are observed for a longer period of time. Because delayed rupture may occur as long as 12 days after injury, patients suspected of damage to the spleen should be under surveillance for at least two weeks.

This does not necessarily imply hospitalization for these patients, but they should be warned and kept in communication. A series of 189 patients who were admitted to the Jefferson Davis Hospital in Houston, from 1946 to 1962, was reported. They were admitted with ruptured spleens and they were alive at the time of admission. The overall mortality was 22%. With a simple splenic injury the mortality was 9%, with a simple stab wound injury—5%, and with delayed rupture it was nihil. Patients with associated injuries had higher death rates, but as the incidence of suspicion rose, the mortality rate decreased. This suggests that suspicion of splenic injury is the key in saving these people. The principles of treatment of this problem are straightforward: take care of associated injuries and remove the spleen. Drains are not used after splenectomy unless there is injury to the pancreas.

Dr. Stuart M. Poticha: Despite its protected location within the abdomen, the spleen is frequently injured with all types of abdominal trauma. Stab wounds are three times as common as other types of penetrating trauma. Since most people are right handed, most victims are stabbed in the left upper quadrant, making the spleen the third most frequently injured organ in penetrating trauma. **The spleen is the most frequently injured organ with blunt abdominal trauma.** This high incidence of splenic injury is best appreciated by considering the



Figure 3. Rupture of spleen that resulted from a fall, caused laceration of capsule of spleen.

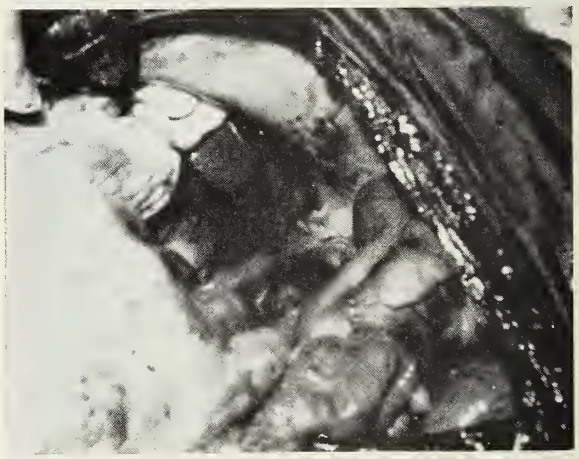


Figure 4. Tear of capsule caused by automobile accident.

mechanisms of injury. First and most commonly, the spleen can be injured by a penetrating missile such as a bullet, knife, or bone fragment. This usually results in immediate severe hemorrhage with signs and symptoms of acute hypotension. Occasionally, the rent in the splenic capsule is covered with a clot while bleeding continues within the splenic pulp. This leads to delayed rupture of the spleen as described by Dr. Monn. Although delayed rupture is more common with blunt injury, it also occurs with penetrating trauma. A stab wound of the spleen may cause a large subcapsular hematoma which may rupture later. (Figure 2).

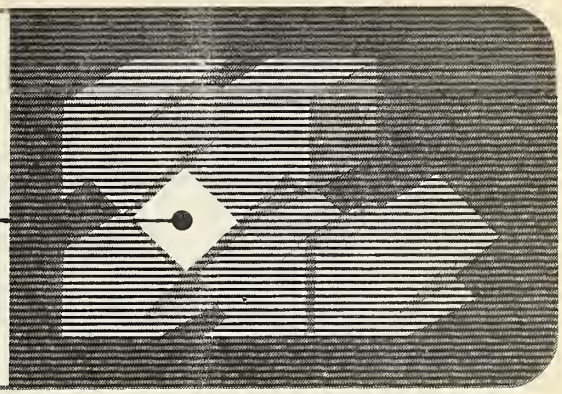
A second mechanism of injury occurs when the spleen is violently compressed between the anterior and posterior abdominal walls. The capsule splits, much as a stepped-on over-ripe orange. That was the mechanism of injury in the patient presented today, (Figure 3).

Another mechanism of splenic injury occurs when there is a sudden rapid deceleration, as might occur in an automobile accident or fall.

(Continued on page 549)

Trauma Center

David R. Boyd, M.D.C.M., Editor



Emergency Department Physician Staffing Patterns and Residency Training

By R. R. Hannas, Jr., M.D./Evanston

Alexandria, Virginia, and Pontiac, Michigan, would appear on the surface to have little in common. In emergency medicine, their common ground is that they are both names of physician staffing patterns for emergency departments.

In 1961, four Alexandria physicians (two internists and two general practitioners) gave up their office practice to become career emergency physicians, based in the hospital emergency department. This set a pattern which has been followed many times since, and as a result the "Alexandria Plan" of physician staffing of an ER means full-time or career emergency physicians-doctors who limit their practice to emergency medicine. At about the same time, in the Pontiac area, a group of physicians joined forces to provide full-time emergency coverage for the hospital on an individual part-time basis. Under this, the "Pontiac Plan," the physicians may work any number of hours or shifts in the ER and retain their own individual practices.

Today, most hospitals have adopted one or the other of these plans to provide physician coverage in the emergency suite or there may be combinations of the two. Sometimes it is necessary, while recruiting full-time or career emergency physicians, to utilize the services of part-time physicians to provide the necessary 24 hour-a-day coverage.



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Which plan is best? Both plans function well under the proper direction and given proper incentives. If the ER patient load is 20,000 or more patients per year with approximately 85% collections, a hospital can probably afford an Alexandria type coverage. If the load is much less than that, then the hospital or the community will probably be providing some sort of subsidy to meet a minimum guarantee or payment to the physicians covering the ER (whether they are full- or part-time. Four physicians can usually handle a workload of 30,000-35,000 visits per year.

Both plans can function with a fee-for-service arrangement with patients or on a salary basis (so much per hour or month or year). If the patient load or the collection rate or both are low, then it will probably be necessary to have a minimum guarantee from the hospital to insure proper rewards for the participating physicians. Experience figures from the operation of the emergency department (especially billing and collecting) are important here.

Any physician, with proper training, can perform as an emergency physician, but the generalists seem to do it better. It is important that

whoever is functioning as an emergency physician has good manipulative skills and be able to make decisions quickly. There are refresher type courses in some parts of the country for physicians going into this field. Most of the present emergency physicians are second or mid-career physicians who have learned their new specialty (for such it is) via on-the-job training. This is an excellent way to learn. Needless to say, the more a physician does something, the more he becomes competent and comfortable doing it. This is an argument in favor of the Alexandria Plan.

Other methods of providing physician coverage include house staff (interns and residents) and hiring "moonlighters." The day of the unsupervised house staff covering the ER should be over: if it is not over in a hospital, then there may be many problems. If moonlighters are hired, be certain that they are qualified.

Whether a hospital has full or part-time emergency physicians or both, there is usually a contract between the physicians and the hospital. Guidelines for this can be obtained in a booklet published by the American College of Emergency Physicians (ACEP) entitled "Emergency Department Management Guide."

In 1970, the American College of Emergency Physicians first developed "Proposed Essentials for a Residency Training Program in Emergency Medicine," and these have been revised from time to time. Nine residencies throughout the country have so far been started using these ACEP guidelines, and several more will begin this summer. A national conference is scheduled for summer of 1973 under the sponsorship of the American Medical Association's Council on Medical Education to help develop official "Essentials" for this type of graduate training program, and this will stimulate the initiation of many more such programs.

Basically, one begins with a defined content—what needs to be taught. In its "Essentials," the ACEP has listed a skeleton content, but any institution can develop this on its own, merely by analyzing its emergency department records for the first year or two in terms of what was treated. The public has defined and continues to define what the content of emergency medicine is by what it brings to the ER. By cataloging or categorizing the various presenting problems into related areas, a curriculum can be developed to teach the necessary content. An audit of experiences should be kept for each resident to insure that he is getting experience in all necessary areas. If the physician needs extra "experience" in some areas, this may be obtained elsewhere, even in different institutions.

The Training Program

The training program is two years, beginning after an acceptable first year of graduate training (internship or other residency). It should be financed as any other hospital residency. The first three beginning residents at Evanston Hospital are financed by a sub-contract under the State of Illinois Total EMS Contract with the Department of Health, Education, and Welfare. A similar program is being initiated at St. Francis Hospital in Peoria. With the University of Chicago emergency physician training effort, there will be three such university-supported programs in the state, and there is a potential in Illinois for six to eight more. Twenty thousand emergency physicians could be placed today and must be trained or recruited.

What does the residency program in emergency medicine do besides training to competence as an emergency physician? When any large group of physicians practices a particular kind of skill or group of skills or in a new specialty area such as emergency medicine, standards must be established and examinations developed to insure that the standards are met. This means Board Certification, and that is not too far away in emergency medicine. Graduates of residencies will be eligible to take the Board examinations when these become a reality. ◄

Five Clues to Schizophrenia

Young schizophrenics can usually be identified by five qualities according to a study of 105 patients that was reported in *Archives of General Psychiatry*. These unique qualities of young schizophrenics are:

1. Disordered thinking
2. Inability to enjoy
3. Overdependence on other people
4. Impaired competence
5. "Exquisitely vulnerable sense of self-regard"

Pediatric Perplexities

Ruth A. Seeler, M.D., Editor

Case Report of Severe Cyanosis in a Newborn Female

By Maria Serratto, M.D./Chicago

A 2½ day-old Puerto Rican female was transferred to the Department of Pediatric Cardiology of Cook County Children's Hospital, because of severe cyanosis since birth.

The infant was born at term following an uneventful pregnancy, labor and delivery with an Apgar score of 10. Her birth weight was 6 lbs. and 3 ozs. The family history was non-contributory. Physical examination revealed severe central cyanosis. The heart rate was 160/min. and regular and the respiration rate was 60/min. The peripheral arterial pulses were normal. The chest was symmetrical and the lungs were clear. On examination of the heart, there was a hyperactive precordium with cardiomegaly, the point of maximum impulse being at the 5th intercostal space lateral to the midclavicular line. There was no thrill. The first sound was normal and the second sound was single. A grade I/VI systolic ejection murmur was present at the left lower sternal border. The abdomen was soft and the liver was 1 centimeter below the right costal margin.

Chest X-ray showed cardiomegaly and increased vascular markings. The electrocardiogram showed right atrial enlargement and right ventricular hypertrophy, which was confirmed by the vectorcardiogram. The patient underwent an emergency cardiac catheterization, which confirmed the clinical diagnosis of transposition of the great vessels. Cine-angiocardiography showed an intact ventricular septum. During the cardiac catheterization procedure, the patient underwent balloon atrial septostomy to produce an adequate interatrial communication. Her clinical status improved, after the balloon septostomy, with a decrease in her cyanosis and she could be sent home two weeks after the procedure on maintenance Digoxin. Her subsequent growth and development were satisfactory, although she remained obviously cyanotic. Definitive, corrective surgery, a Mustard procedure, was performed when she reached the age of 2 years. At that time, her weight was 25 lbs. and 8¼ ozs. Following the corrective surgery, the child is completely asymptomatic, quite active and doing extremely well.

Discussion

Congenital heart disease accounts for approximately 0.8% of all malformations occurring at birth, but is responsible for 50% of deaths caused by all types of congenital anomalies in the first months of life. Transposition of the great vessels is one of the most common of the serious heart diseases in newborns and infants and ranks first among those whose principal manifestation is cyanosis.[1] Severe central cyanosis was the presenting manifestation in this infant. In patients with transposition of the great vessels and an intact ventricular septum, murmurs may be absent or insignificant, as in this case, and clinically the diagnosis is based on the presence of a single second sound, a hyperactive precordium and cardiomegaly. Confirmatory evidence is obtained by cardiac catheterization and cine-angiocardiography.

Swift handling is mandatory to salvage these extremely sick babies whose course is rapidly downhill. This can be accomplished by balloon atrial septostomy.[2] The balloon procedure is carried out at the time of cardiac catheterization and consists of the creation of an interatrial communication with a balloon catheter. Under fluroscopic monitoring, the balloon is introduced in the left atrium from the femoral vein via the right atrium and the patent foramen ovale. The balloon is inflated with contrast medium and forcefully pulled back through the foramen ovale to produce a tear in the atrial septum.



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Since in transposition of great vessels cyanosis is mainly related to the amount of blood interchange between the pulmonary and systemic circulation at the atrial, ventricular and arterial level, the balloon atrial septostomy improves the systemic oxygenation by increasing the mixture of systemic and pulmonary blood at the atrial level. Balloon atrial septostomy also improves the congestion of the lungs by venting the left atrium.

The importance of palliative techniques for treatment of congenital heart disease in the early postnatal period and infancy cannot be over-emphasized. The majority of the cardiac lesions are amenable to corrective surgery, but the mortality and morbidity are very high at this early age. It is, therefore, necessary to improve the circulatory derangement present in these infants, until definitive surgery can be performed safely. In addition to transposition of the great vessels, balloon atrial septostomy has proved effective in total anomalous pulmonary venous connection (without pulmonary venous obstruction)[3] tricuspid atresia, pulmonary atresia with intact ventricular septum, critical Ebstein's malformation of the tricuspid valve and mitral atresia.[4] In skilled hands, balloon atrial septostomy is a safe, life-saving procedure with a very low incidence of complications.[3]

In addition to the balloon atrial septostomy, management consists in the control of congestive heart failure and infection until such age when complete correction is feasible. ◄

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Follow up Drug Therapy

I ask my patients to bring in their medication bottles at each follow-up evaluation. I request that they bring not only drugs which I have prescribed but any drugs obtained from other physicians or over-the-counter medications which they may be taking. While I am looking at the bottles I ask the patient *how* they are taking the medications. This gives me an opportunity to (1) know all the drugs that the patient is taking and thus be alert for possible drug interaction, (2) have an estimate as to whether the patient is taking his medication in the manner and quantities prescribed, and (3) sometimes discover additional medical problems that the patient has failed to mention to me.

Pediodically I ask patients to bring in any old medicines they may have in their medicine cabinet and we get together decide what, if any, should be kept. This helps reduce the possibility of adverse reactions to "look alike" medications and reduces the supply of potentially dangerous outdated medications which tend to accumulate in many homes. As we go through the old medications, I frequently ask the patient the condition or purpose of each of the medicines. It is very instructive to discover the misperceptions which patients accumulate, either from inadequate explanation to begin with or through their own misinterpretation of the physician's statements. (Regarding the "Take Thou" article on prescribing practices. *Drug Therapy* [Letters—Donald R. Wesson,] Feb., 1973, pg. 16).

Colorectal Adenomas and Adenocarcinomas

By James Graham, M.D./Springfield

Any discussion of a possible adenoma-carcinoma sequence in the colorectum is certain to evoke listing of distinguished authorities "for" such a concept[3,5,6,12,13,20] and an equally impressive array of authorities "against."[4,10,14,15,17,19]

Adenoma-carcinoma sequence means metamorphosis and progression from normal colonic and rectal mucosa to adenoma; to "in situ" carcinoma; to invasive carcinoma; to metastasis and death.

Majority opinion has swayed back and forth over the years, with extremes ranging from "eventually 100% of colonic polyps become malignant"[7] to "have never observed."[21] The prevailing opinion today is that while it is possible for such metamorphosis to occur in a simple adenoma and to proceed to invasive carcinoma, the overwhelming majority of colorectal carcinomas arise either *de novo* from normal epithelium or from villous adenomas.[19]

The importance of considering an adenoma-carcinoma sequence is the reasoning that if all adenomas represent potential cancers, then all of them should be searched out and removed or destroyed. If, on the other hand, only an insignificant percentage of adenomas or no adenomas have cancer potential, the important question in the face of a polyp is not one of sequence or what the polyp might become, but a question of whether the polyp is actually an adenoma or an adenocarcinoma. In terms of surgery this could mean no operation, a simple operation for a benign tumor, or a radical cancer type operation.

Much confusion stems from a lack of preciseness in the use of terms, both for gross anatomic description and for histological differentiation. The terminology need not be complex. For example, *polyp, simple adenoma, villous adenoma* and *adenocarcinoma* form an adequate working vocabulary for describing gross patterns. Likewise, the terms *atypia, in situ* and *invasive* convey images of histologic characteristics sufficiently inclusive to distinguish abiologically benign from biologically malignant lesions, or those that remain localized from those that metastasize.

Until a histologic diagnosis has been established for an enlargement in the colon or rectum, perhaps it is best clinically to label it a *polyp*. The term is non-specific. It includes any soft, pedunculated or sessile, mucosa-covered mass. Ordinarily, polyps are detected by endoscopy or by X-ray examination. Some polyps are nothing more than mucosal bumps and excrescences or enlarged lymph follicles. Most of them, however, (95%) are glandular tumors of some kind, benign or malignant, that is, adenomas or adenocarcinomas.

Once a specific diagnosis has been made by the pathologist this diagnosis should be used rather than "polyp" and rather than a variant of polyp, such as malignant polyp or adenomatous polyp.

Harmless mucosal *excrescences* are almost always of less than five millimeters diameter. These bumps comprise about five per cent of the elevations seen through a sigmoidoscope. Most of them can be looked upon as hypertrophic mucosal tags. So long as they are less than five millimeters diameter, half-domes and covered with a smooth mucosa they probably can be considered insignificant; however, they can be cancerous.[16]

An *adenoma* is a tumor of gland-like structure, circumscribed and encapsulated, arising from glandular epithelium.

In a *simple adenoma* the cells are of normal glandular pattern and are supported by a thin fibromuscular stroma, the lamina propria. Once a histologic diagnosis of adenoma has been made, that is the only term necessary. Polyp and benign as further descriptive words, for example, be-

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nign adenomatous polyp, are only misleading. An adenoma is benign by definition: it need not be called benign. It is worthwhile, however, to distinguish sessile from pedunculated. A pedicle is a relative safety factor. It is likewise proper to specify simple adenomas and villous adenomas because of the differing histologic and biologic characteristics of the two types.

A *villous adenoma* is a glandular epithelial neoplasm with finger-like projections that give the surface a shaggy appearance in the gross. The villous epithelium, resting upon a fine vascular stroma, sometimes secretes large amounts of mucus. Villous tumors may be either benign or malignant and hence they are referred to either as villous adenomas or villous adenocarcinomas.

Most glandular neoplasms are of a single type, either simple adenoma, villous adenoma or adenocarcinoma, but they may be mixtures of these. A mixed tumor will have the biologic characteristics of its most aggressive portion.

Polypoid carcinoma is an anatomical description for an adenocarcinoma that is drawn out into the colonic lumen with is base stretched into a neck and its center expanded into a bulbous head like that of a mushroom.

Atypia is demonstrable in almost all colorectal adenomas. Here, the surface cells exhibit some of the histologic features of cancer, ranging from variation in size and shape of the glands, hyperchromatic nuclei and cellular depolarization to reversal of the goblet-secretory cell ratio and mitotic figures.

In situ carcinoma shows all of the histologic characteristics of carcinoma, but with the process contained entirely inside the lamina propria. There is intraglandular budding and infolding to make glands within glands.

Invasive carcinoma is manifested, in the view of most pathologists, by direct extension of cancerous cells and glands into and through the muscularis mucosae. Some investigators do include as invasive carcinoma collections of malignant cells that invade and disrupt the lamina propria but do not penetrate the muscularis mucosae.[9]

A Benign-Malignant Sequence

There is persuasive evidence for an adeno-carcinoma sequence in the demonstrations of benign areas (adenoma remnants) within tumor masses of adenocarcinomas. Such tumors actually are mixtures of adenoma and adenocarcinoma with the latter predominating. In these situations a malignant process apparently develops within a benign lesion. Enterline and his associates found such adenoma remnants in one per cent of colorectal carcinomas.[9]

Conversely, malignant tumors are found inside benign tumors.[5,13,20] Adenocarcinomas have been demonstrated within primarily adenomatous and pedunculated lesions, penetrating the muscularis mucosae and the stalk. These are areas of frank invasive carcinoma, not atypia or carcinoma in situ. Culp[5] reports partially ulcerated adenomas or "wine glass" lesions caused by carcinomatous involvement. There is strong suggestion here of transformation from benign to malignant neoplasm. When, in addition to this evidence, distant metastases are observed in the same patient, the facts become very convincing.[7,11,13]

It has been pointed out that such invasive carcinomas do not become metastatic unless they extend into and occupy a part or all of the stalk.[17] The idea here is that if malignant cells cannot metastasize, they are not biologically malignant. Thus, some apparently invasive cancers may not be truly malignant. For the pedunculated adenomas whose stalks contain carcinoma there is abundant evidence that the contained carcinomas do metastasize.[11,13]

Bacon[1] found 11% of cancers of the colon and rectum showing evidence of having arisen from adenomas. Lescher and his associates reported 7% of distal colonic adenomas exhibiting invasive carcinoma.[12] Dockerty also found four instances of adenomas with invasive carcinoma and negative stalks but with lymph node metastases.[8]

Circumstantial Evidence

The circumstantial evidence offered in support of an adenoma-carcinoma sequence is intriguing, but most of it is contested.[10] Confusion and disagreement arise from variations in terminology and in the methods of collecting and recording statistical information.

Some observers report that 50% of adenocarcinomas of the colorectum are accompanied by adenomas. Some collective figures indicate that carcinoma of the colon and rectum occurs three times as frequently in patients with multiple adenomas in contrast to those who have only solitary adenomas.[2] Culp reported 25% of patients with colorectal carcinomas having satellite adenomas, of which 5% showed invasive carcinoma. Another argument for an adenoma-carcinoma sequence is that atypia and carcinoma

in situ are observed only in adenomas and not in grossly normal colonic and rectal mucosa.[3]

Stearns[18] asked, "Where are the tiny cancers of the colon and rectum?" He pointed out that tiny clinical cancers are found only in adenomas and that minute sessile cancers occur too infrequently to explain a *de novo* origin for the majority of cancers of the colon and rectum. In this vein, in a series of more than 26,000 proctosigmoidoscopies at the Mayo Clinic no tiny initial cancers were discovered.[5]

There is disagreement with the validity of most of this circumstantial evidence. Spratt, Ackerman and Moyer[17] analyzed a Barnes Hospital series of 243 adenocarcinomas of the colon accompanied in 53 instances by adenomas. They were unable to verify a seeming concordance of the distributions of these benign and malignant tumors. They found also that satellite adenomas accompanying carcinomas were not located randomly. From these studies they concluded it was unlikely that the carcinomas in their series had their origins in adenomas. Spratt and Ackerman[16] reported 20 carcinomas of less than two centimeters, one of them only two millimeters. So, it is possible to find tiny cancers. Turell and Haller[19] in an extensive review of the subject concluded that a true incidence of colorectal adenomas is not known and that therefore it is impossible to relate their incidence to that of cancer.[19]

Thus, the circumstantial evidence for an adenoma-carcinoma sequence is contested vigorously.

Evaluation

Obviously, the question of an adenoma-carcinoma sequence cannot be answered unequivocally. This being the case, the risks involved in destroying or removing all colorectal polyps in an attempt to prevent or wipe out the seeds of potential cancer are not warranted. Some polyps are harmless and asymptomatic and therefore no risks at all would be justified in removing them.

The real problem is determining which polyps (undiagnosed lesions) are cancers and which lesions are not cancers. The question in any given case can be decided with finality only by complete histologic examination of the totally removed polyp. Partial or fractional biopsy ordinarily will not do because this may leave the surgeon in as inconclusive a situation as when he started. True, if the examination shows invasive cancer, the evaluation is conclusive. If, however, the specimen proves benign, there is no assurance that the portion of tumor remaining in the patient does not contain cancer. Nothing short of total removal and complete biopsy will provide an answer and solve the problem of whether the polyp is benign or malignant.

Is histologic diagnosis necessary for each and every polyp? If this is necessary, then every polyp must be removed under any circumstances because any polyp could be a cancer. But aren't there features of polyps that make some of them statistically less likely to be cancers? Aren't some of them reasonably safe when balanced against the risks of removing them, particularly in respect to age, obesity, cardiovascular disease, diabetes and other unfavorable conditions? Laparotomy does carry measurable risks even in apparently healthy persons.

The answer to risk is that undiagnosed polyps of greater than one centimeter and unspecified villous tumors are more likely to prove cancerous than small polyps and simple adenomas. Although tiny cancers are encountered in the colorectum, it is still true that the larger the polyp the greater is the chance for cancer. Size, therefore, is important, and is a factor in risk. Additionally, a villous pattern is important since one-third of villous tumors are malignant.

Very few well pedunculated polyps of less than one centimeter prove to be polypoid cancers or show invasive carcinoma in their stalks. Hence, the chance for biologic malignancy or the capability for metastases is slim in pedicled tumors of this size. Such polyps can be observed endoscopically and by X-ray at three to six month intervals. If there is any doubt about the presence of a pedicle, this feature can be determined by sigmoidoscopy or by fiberoptic colonoscopy.

The margin of safety is less with sessile tumors. If a sessile lesion of even less than a centimeter has a shaggy or ulcerated surface, if the lesion bleeds readily, or if there is fixation as determined by endoscopy or X-ray, then the tumor should be removed in its entirety either transanally or by laparotomy and colotomy. Carcinomas of only two millimeters are reported. There is always the possibility that the sessile mass is villous. While few pathologists subscribe to a simple adenoma-carcinoma sequence, most of them agree that metastasizing carcinomas do arise in villous adenomas.

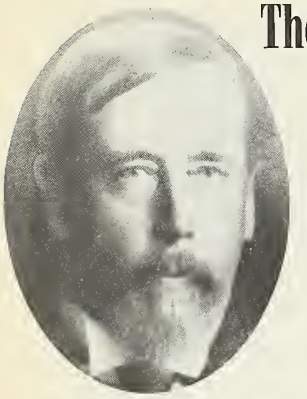
Summary

Prevailing opinion allows the possibility of metamorphosis of simple colorectal adenomas to invasive and metastasizing adenocarcinomas; but holds at the same time that the overwhelming

(Continued on page 545)

The Physician as the Guardian of the Public Health and His Contributions to Charity*

By John N. Phifer, M.D.



John N. Phifer, M.D.

Ladies and gentlemen, we have invited you to be present tonight, that we might on this our annual meeting, bring before the public some questions which we consider of general interest. We think that the public should know something of our hopes, our aspirations, our successes, and our failures, something of what our profession has done in the past toward safeguarding the general health, and what is now being done; as the success of our efforts depends in a great measure upon the cooperation that we may receive from you.

The position held by the physician is to a certain extent semi-official in that many problems concerning public health are left to his decision, and his training and experience peculiarly fit him for this work. Of his position as medical advisor in your family you are all familiar. You know that where danger threatens, when life's thread seems near to breaking, when hope weakens, how you search the countenance of your physician for encouragement, how you hang upon his every word for tidings to drive away your fears. You all know how pleased he is when he can assure you that the danger is past; the patient will recover. How many thousand times all of this is enacted and how naturally the physician comes to be looked upon as almost a guardian, a protector of the family. And how fortunate is that physician who may be thus held in the affections of his clientele, and to feel that his efforts are so well appreciated. Well may he strive to render himself more worthy of their confidence and esteem.

John N. Phifer, M.D., was born on a small farm near Mansfield, La. in 1848. He was largely a self educated man having attended a small country school, followed by two, three month, courses at Tulane Medical School. In 1869 he and his parents moved to Vandalia, Ill. and he began his practice in Moccasin, then having a population of about 20. A year later he moved to Shumway (Effinghom County) where he was one of the first settlers. He continued practice in this area until his death in 1922.

He had two sons who practiced medicine in Chicago. The late Dr. Charles H. Phifer was at one time President of the Illinois State Medical Society, in 1945, and Dr. Frank M. Phifer specialized in urology. Dr. Frank M. Phifer is now retired and living in Eureka, where his son, Dr. Joe C. Phifer, is in general practice.

**This was Dr. Phifer's presidential address given before the Effingham County Medical Society in 1900. The public was invited. Ed. Note:* Many points raised by Dr. Phifer have application today, seven decades later.

The physician is with you from the cradle to the grave, for disease and death are parts of the plan of creation. We have to deal with both, and to combat them; to prevent and lessen one, and prevent the other if possible, to stay the hand that hurls the dart that strikes but once.

We consider it a large part of our mission to prevent disease, to study the existing cause, to learn something of the life history of the germ or infection which may be responsible for the disease. Today this branch of medicine is called preventive medicine and it is of the greatest importance to the public in regard to general health.

We feel justified in saying that there has scarcely been a time since medicine became recognized as a science, which does not bear witness to the self-sacrifice and devotion of our profession in behalf of humanity: "In war, famine, and pestilence our brethren have always been found" among those who suffered, "sharing their dangers and hardships."

Long before, what we now know as "preventive medicine" was systematically taught medical men in the dim light. They were then possessed endeavoring to find and remove the cause of disease. We will not review their efforts or results but confine our remarks to more recent times, though volumes could well be written of the long and patient efforts of many of the worlds greatest minds such as Jenner, Hunter, Harvey, Pasteur, Behring, Kock, and many others who with wonderful patience, great skill, and a lifetime of study have placed milestones along the march of human progress, and all future generations will ever revere their names and memories. They and their successors in research, investigation, and experimentation, in preventing diseases, have saved the world's family countless thousands of valuable lives, and millions of wealth.

Their findings have rendered vast regions of the world fit for human habitation where formerly disease and death held high carnival. Consider what would be the condition today in any of our large cities without the benefits of sanitary services, the fruit of the brains of these men. For how long a time would Paris, London, New York, or Chicago, with their teeming millions of people exist, without enforcement of the sanitary laws which embody the results of the observations and advice of scientific medical men?

In a somewhat varied degree the same observation holds true with our smaller towns and homesteads in the country, and that we do not all perish from some form of disease is certainly not due to our observance of sanitation, but rather to the benefits of fresh air and that we lead an out of door life. The human family has as deadly

enemies many diseases which from their known or suspected cause, are called preventable diseases, and filth, and bad hygienic conditions furnish the culture medium, wherein the germs of these diseases exist and thrive. Wherever you go you will find the medical profession earnestly advising and always protecting against bad sanitary conditions, and there is no doubt that were our advice followed, we would be able to eradicate, to a large extent, many such diseases as small pox, cholera, scarlet fever, measles, typhoid fever, yellow fever, consumption, and malaria.

The study of the various preventable diseases has engaged the time and skill of numbers of the ablest men in the past, and at the present time a vast army of scientific investigators is waging relentless war upon these deadly enemies of our race. To a large extent, this is a labor of love upon the part of these men, for the good of mankind. For the uplifting of our noble profession, there are no niches in the hall of fame, but nevertheless their names will be honored and perpetuated as benefactors.

All of this study, investigation, and experimentation in the cause, nature and prevention of disease will avail little, unless our efforts are aided by individual and governmental support. It is your duty to protect your home from diseases and to do this you should demand of your officials that sanitary laws be enforced and you should set the examples by obeying the laws yourselves. In this way and in this way only, can our labors bear fruit and lessen the number of sick and prevent disease. Another point which I wish to express is that all of this study in preventive medicine at the bedside and in the laboratory, has been done by quiet, unassuming men in the regular profession, who have given and are giving freely to the world the benefits of their labors. The men who advertise, the men who make periodical visits to your town, and the fellow who drives from house to house in the country and catches the farmer upon a "sure cure," have had nothing and cannot have anything whatever to do with this work, as they are not physicians in sentiment or ethics and should be barred from practice. Therefore it seems a matter of common justice that you should with moral and financial support uphold the regular profession. Your family physician whose teachings, whose traditions, lead him to hail with joy and gladly give to his profession whatever he may learn or discover that will in any way relieve suffering humanity.

We have made it possible to eradicate small pox by thorough and systematic vaccination. We have by the use of the serum treatment reduced the old mortality rate in diptheria 50 to 75%. And by the use of the immunizing or protecting power of the serum on those exposed to infection to limit the number of cases thus save thousands of children who previously to the introduction of the serum treatment who would have fallen victims to this dreaded disease. We have banished yellow fever from the North American continent and adjacent islands and the time is coming when by enforcement of our sanitary laws and measures, this disease will no more strike terror to our hearts nor demoralize the commercial interests of half a continent. We have made substantial advancement in other diseases along the line of preventive measures, and are still studying and investigating to the end that we may in time control them.

And last but not least, we are engaged in a general crusade against "the great white plague," consumption. We now know it to be a communicable disease, an infective disease. We now know that a consumptive person is a menace, a danger to those around him, whether in his own house, or on the streets or public conveyance. Our profession is constantly pleading for care on the part of the consumptive and his attendants that he be so controlled and so control himself, that he may not infect others and thereby spread the diseases. The study of the germ life history in the various preventable diseases is very dangerous to the student, as many men have fallen victims to these deadly infections. But others are ever ready to take on the work.

In times of great peril, when deadly epidemics sweep the land, the physician never falters nor deserts his post. Not that life is not sweet to him, but being inspired by the example of generations of his illustrious predecessors, duty calls and he fails not.

You remember, no doubt, the fearful epidemics of yellow fever a few years ago which devastated the south where thousands perished in New Orleans, Memphis, and other cities, and you remember the pathetic appeal for help. The local physicians were worn out, sick, or dead, and the sick were without medical attendance. When this word went abroad, physicians volunteered. They went from the north, east, and west to aid suffering humanity. No crusader who with sword and shield went forth to free the Holy City was inspired with higher, nobler purpose than were these brave men, many of whom fell victims to their zeal and their bodies rest today "under southern skies," their sad requiem the moaning of the pines.

So it is in every instance, our profession knows no fear where a human being calls for help. We brave the summer sun and the winter's storm, as well for the poor as for the rich. We give our time, our skill, our money, and sometimes life itself in behalf of the poor. Our contribution in the cause of charity exceeds that of any other class of citizen, with us it is not a fad to give our services to the poor, nor a solace to quiet a disturbing conscience, but it is a part of our every day life work.

In closing I wish to introduce to you an old and very dear friend, William MacClure, "a doctor of the old school" in the Bonnie Briar Bush. I hope that you will study him, for if you do, you will admire him. He has many prototypes. They are to be found in every city, town, and village in all this broad land. They are here tonight. They have risked their lives often to save yours and are ready and willing to do so again. They are your own family physicians. Some of them have grown old and gray in your service. Their steps are feeble and their forms are bent. When they have answered their final call, write their epitaphs as was written that of Dr. MacClure's "Greater love hath no man than this; that he lay down his life for his friends." ◄

Cumulative Index

for

Volume 143

on page 551



A VERY SOUND BARRIER



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Ortho All-Flex Diaphragms are made of high quality, long-lasting latex. They won't discolor when used with Ortho-Gynol Contraceptive Jelly or Ortho-Creme* since these contain no phenylmercuric acetates. No introducer is needed, the unique spring-within-a-spring construction forms a perfect arc wherever compressed.

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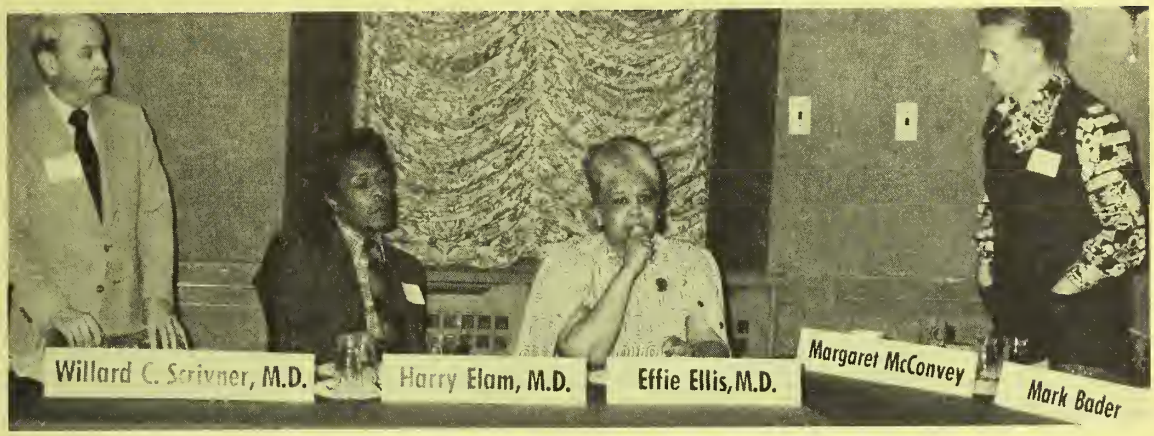
The Ortho All-Flex* Diaphragm with Ortho-Gynol* Contraceptive Jelly

*Trademark

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Doctor's News

Hearing Held on Health Problems



Willard C. Scrivner, M.D., (far left) ISMS President, served as moderator at a hearing on health care problems. The hearing, which was recently held in Chicago, was attended by over 40 representatives of community organizations, health agencies, volunteer groups, government, members of the ISMS Committee on Health Care of the Poor, and ISMS officers. The participants urged Illinois physicians to take the lead in coordinating and publicizing the wide range of health services available to the urban and rural poor.

Major obstacles to providing quality health care for the minority groups, the elderly and those from rural areas who have difficulty adjusting to urban life, were listed by the spokesmen: (1) lack of coordination of services and programs, leading to duplication in some areas and scarcity in others; (2) cost of health and medical care; (3) difficulties in making the poor aware of services and facilities available to them, and problems in transporting them to medical facilities; (4) shortages of physicians and other health care manpower in many Chicago neighborhoods; (5) lack of health education, and especially a lack of knowledge about nutrition and the ill effects of improper diet; and (6) environmental conditions which cause poor health.

As a result of this hearing, the ISMS Committee on Health Care of the Poor immediately assigned a high priority to exploring ways in which the medical society can help co-ordinate services.

PHYSICIANS URGED TO OPPOSE THE HEALTH CARE LICENSURE ACT—House Bill 1414 (Health Care Licensure Act) is an "omnibus consumer measure" that would hamper the practice of medicine in Illinois. ISMS Board of Trustees is urging physicians to help fight this bill by contacting their legislators. Some of the damaging items included in the bill are: (1) appointment of a consumer and a "related health professional" to the Medical Examining Committee; (2) creation of a "Super Board" to set proficiency equivalency standards for career mobility of health care professionals and (3) creation of a "Grievance Bureau" to investigate consumer complaints against health care professionals and facilities. Other elements of the bill would make continuing medical education a requirement for re-registration by 1977; provide for a central computerized registry of licensed health professions and establish a health section within the Department of Registration and Education.

U. OF I. RECOGNIZES PHYSICIANS FOR SERVICE—At a Service Recognition Program, at the University of Illinois Medical Center, several physicians were honored for their years of service to the University of Illinois College of Medicine.

Physicians having served for 25 years include **Doctors Joel S. Handler, Leon J. LeBeau, Armand Littman, Richard E. Marcus, Edward A. Piszczek, Theodore Z. Polley, Milton Robin, Phillip Shambaugh, Oscar Sugar, Seymour Weisberg** and **William Wesidorf.**

Upon retirement the following physicians were recognized: **Doctors George O. Baumrucker, Frederic A. Gibbs, Carlo Scuderi, Phillip Shambaugh, Frederick Steigmann** and **William F. Waldrop.**

ANNOUNCEMENT FROM HEW—The U. S. Health and Nutrition Examination Survey of the Public Health Service will shortly be conducting operations in the Counties of McHenry, Lake, Cook, and DuPage. The initial phase will begin on July 9, with interviewers from the U.S. Bureau of the Census calling on selected households in the sample area to obtain certain demographic information about each household and the individuals who live in them. Following this, approximately 444 persons between the ages of 1 and 74 years will be selected by a statistical sampling process to participate in the examinations. Examinations will be conducted during August 4-September 5, 1973, in the survey's mobile examination center.

The survey has a dual purpose—to measure the nutritional status of the United States population between the ages of 1 and 74, and to obtain information on the health status and medical care needs of persons between 25 and 74 years of age. The examination is designed primarily to collect statistical data on health and medical care needs and nutritional status. Results of the examination are not disclosed to the examinee, but a report of findings of the examination are sent to the person's physician and dentist upon request.

PHYSICIANS IN THE NEWS—Appointments at Cook County Hospital include **Gerald Burke, M.D.**, as chairman of the Department of Endocrinology and **Whitney Addington, M.D.**, as head of the Department of Pulmonary Diseases.

Harry Kurz, M.D., Lincolnwood, has been named Director of the Albany Park Family Health Center, Chicago. **Samuel P. Gotoff, M.D.**, is the new Chairman of the Department of Pediatrics at Michael Reese Medical Center, Chicago.

At the Annual Meeting of the Chicago Urological Society the following officers were elected: President, **Herbert Sohn, M.D.**, Vice President, **George G. Curl, M.D.** and Secretary-Treasurer, **Charles F. McKiel, M.D.**

Bruccio E. Salvo, M.D., Chicago and **Gwendolyn Schmidt, M.D.**, Chicago were recently certified as Fellows of the American College of Anesthesiologists.

Robert C. Stepto, M.D., Chicago, won First Place in the 1972 Wine and Health Writing Competition for his entry "Wine—That Extra Ingredient for Patient Care."

C. Larkin Flanagan, M.D., is the new Chief Editor of the *Proceedings of the Institute of Medicine of Chicago.*

Maurice H. Cottle, M.D. Is "Citizen of the Year"

The Board of Trustees of the Illinois Masonic Medical Staff recently paid tribute to Maurice H. Cottle, M.D., 75, as the "Citizen of the Year." Dr. Cottle, a surgeon, author, researcher, teacher, and inventor, has served for 49 years on the Illinois Masonic Medical Staff. He was the first President of both the American and International Rhinologic Societies.

As an inventor, he developed the Cottle Nasal Breathing Pressure and Flow Recorder. This machine measures breathing pressures and their relationship to the rate of flow of air through the nose. His Cottle Recorder, which formalizes and standardizes rhinologic examination, is incorporated in every examination given at the Mayo Clinic.

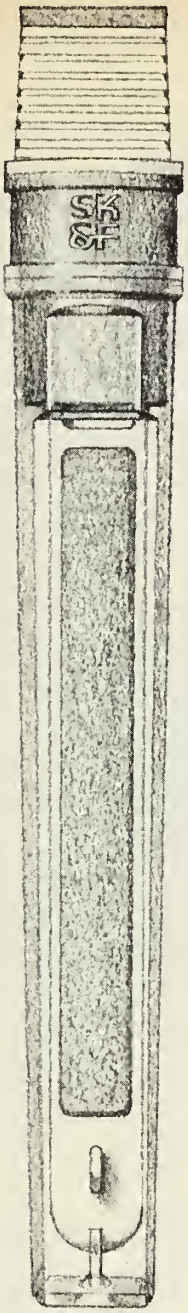
Among his outstanding honors, Dr. Cottle received the University Gold Medal of Honor which was conferred upon him by the University of Lerdin, Netherlands, in 1968. He is one of only three United States citizens who have been so honored.



Maurice H. Cottle, M.D.

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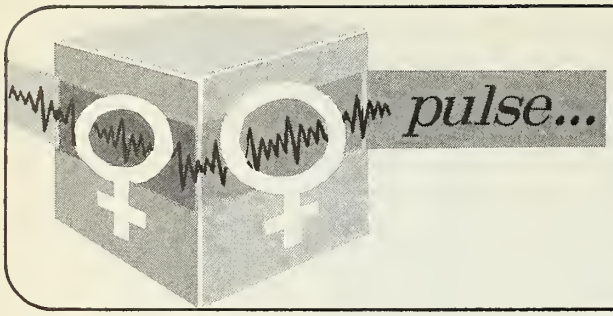
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pulse... of the doctor's wife

Mrs. Roseanne K. Frank, *Editor*

Mrs. Pitcher Contributes To Health Education Fund



During the ISMS/WA Annual Meeting, Mrs. Betty B. Pitcher (center) presented a check to the Woman's Auxiliary Health Education Fund. Receiving the check were Mrs. Wendell Roller, Monmouth (left) and Mrs. Eugene Vickery, Lena (right).

Two auxilians were thoughtful enough to invite a friend to convention, and as a result the ISMS Auxiliary is $1,000 richer in its health education fund! Mrs. Eugene Vickery, Lena, and Mrs. Henry Schorr, Chicago invited their friend Betty B. Pitcher to the annual meeting of ISMS/WA. She listened to the proceedings and the reports and was so impressed with what the auxiliary is doing that she decided to contribute the sum of $1,000 to Health Education—education for survival, personal well-being, and social fulfillment. Appreciating the heritage and values of our country she felt the importance of the efforts we are making to promote mental as well as physical health.

Mrs. Pitcher's concern for health care is a lifetime interest undoubtedly influenced by her grandmother who was one of the first women physicians to practice in the Freeport area. Her grandmother also had two brothers who were physicians. Mrs. Pitcher's concern takes the form of financial aid such as the $1250 she gave earlier this year to the Highland Community College Practical Nursing program in Freeport.

A woman who is very much at ease on the speaker's platform, an accomplished musician, a writer of poetry, Betty Pitcher charmed her audience to a rousing and enthusiastic ovation at the time she presented her gift to auxiliary.

Cheers For Mrs. Wiltsie

There is always at least one in each auxiliary —that individual who works quietly all year around, year after year, and never seems to be around when the photographers are taking the pictures! St. Clair county seems to have one such in the person of *Mrs. David Wiltsie*. She raises fantastic amounts of money for AMA-ERF, and gets it all in by November. Due to the labors of her kind of people, St. Clair County got the first three awards this year at convention!

Editor's Note: We would like to hear about YOUR faithful workers, county officers.



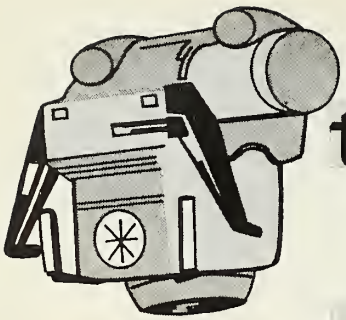
Mrs. Willard (Ruth) C. Scrivner, (center) gathered with members from her county, St. Clair, at the annual meeting in Chicago. The First Lady of ISMS, Mrs. Scrivner will be installed this month as the new WA/AMA President at the AMA Clinical Conference in New York.

Pictured are (left to right): Mrs. Edward Szewczyk, Mrs. John Hipskin, Mrs. Wilson West, Mrs. Julian Buser, Mrs. Scrivner, Mrs. Robert Hardin, Mrs. H. Frank Holman, Mrs. Tom Meirink and Mrs. Joseph Santiago.

In Memoriam 1972-1973

Balthazar, Mrs. E. R.	Kane	Nov. 1972
Bartling, Mrs. Carl	Winnebago	Nov. 1972
Burgess, Mrs. John P.	Rock Island	July 1972
Conroy, Mrs. William J.	Sangamon	
Dolley, Mrs. Homer	McLean	Dec. 1972
*Gariess, Mrs. Alfred	Cook	April 1972
Hanson, Mrs. J. K.	Rock Island	Nov. 1972
Lukaszewski, Mrs. Edwin	Cook	Feb. 1973
McCuistion, Mrs. H. P.	Madison	
Miller, Mrs. H. P.	Rock Island	Jan. 1973
Rankin, Mrs. James Tyler	Winnebago	July 1972
Rice, Mrs. I. P.	Kane	Dec. 1972
Rosenblum, Mrs. Samuel	Marion-Clinton	
Rothenberg, Mrs. Morris	St. Clair	Jan. 1973
Wall, Mrs. Frank J.	Cook	June 1972
Wehrspann, Mrs. Donald	Will-Grundy	Sept. 1972
Wagenknecht, Mrs. Theodore W.	LaSalle	

**WA/ISMS President 1944-46*



the view box

Leon Love, M.D./Chairman/Department of Radiology
Loyola University Stritch School of Medicine



Figure 1



Figure 2

The patient is a 53-year-old male who complained of pain in the back and right upper quadrant of about two years duration. Examination of the abdomen, Scout films (Figure 1) and upright film of the abdomen were done. Physical examination was not contributory.

What's your diagnosis?

1. Gallstone
2. Milk of calcium renal stone
3. Hepatic calcification
4. Appendiceal calcification

(Answer on page 545)



new pharmaceutical specialties

By Paul Dehaen

For detailed information regarding indications, dosage, contraindications and adverse reactions, refer to the manufacturer's package insert or brochure.

Single Chemicals—Drugs not previously known, including new salts.

Duplicate Single Drugs—Drugs marketed by more than one manufacturer.

Combination Products—Drugs consisting of two or more active ingredients.

New Dosage Forms—Of a previously introduced product.

The following new drugs have been marketed:

DUPLICATE SINGLE DRUGS

ADAPIN — Psychostimulant and tranquilizer ℞

Manufacturer: Pennwalt Corporation, Rochester, N.Y.
Nonproprietary Name: Doxepin HCl
Indications: Anxiety and depression
Contraindications: Glaucoma and urinary retention
Warning and Precautions: See package Insert
Dosage: 10 to 25 mg. t.i.d., may then be reduced, adjusted to patient's response.
Supplied: Capsules 10, 25, and 50 mg.

DOLENE 65 — Analgesic ℞

Manufacturer: Lederle Laboratories, Pearl River, N.Y.
Nonproprietary Name: Propoxyphene HCl
Indications: For the relief of mild to moderate pain.
Contraindications: Do not use in children; use with circumspection in pregnancy.
Precautions: Tolerance has been reported in some patients.
Dosage: 65 mg. t.i.d. or q.i.d.
Supplied: Capsules 65 mg.

SK-65 — Analgesic ℞

Manufacturer: Smith Kline & French
Nonproprietary Name: Propoxyphene HCl
Indications: For the relief of mild to moderate pain.
Contraindications: Do not use in children; use with circumspection in pregnancy.
Precautions: Tolerance has been reported in some patients.
Dosage: 65 mg. t.i.d. or q.i.d.
Supplied: Capsules 65 mg.

DOLENE Compound 65 — Analgesic ℞

Manufacturer: Lederle Laboratories, Pearl River, N.Y.
Composition: Propoxyphene HCl 65 mg.; Aspirin 227 mg.; Phenacetin 162 mg.; Caffein 32.4 mg.
Indications: For the relief of mild to moderate pain.
Contraindications: Do not use in children; use with circumspection in pregnancy.
Precautions: Tolerance has been reported in some patients.
Dosage: Three or four times daily.
Supplied: Capsules

SK-65 Compound — Analgesic ℞

Manufacturer: Smith Kline & French
Composition: Propoxyphene HCl 65 mg.; Aspirin 227 mg.; Phenacetin 162 mg.; Caffein 32.4 mg.
Indications: For the relief of mild to moderate pain.
Contraindications: Do not use in children; use with circumspection in pregnancy.
Precautions: Tolerance has been reported in some patients.
Dosage: Three or four times daily.
Supplied: Capsules

NEW DOSAGE FORMS

HERPLEX — Eye Preparation, Antiviral ℞

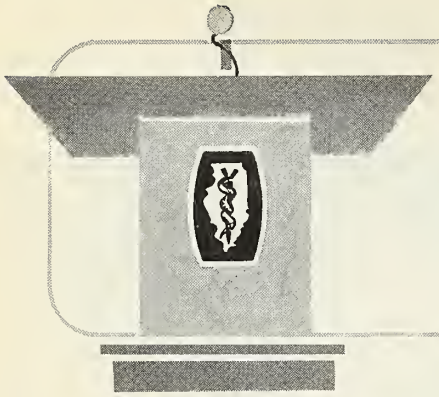
Manufacturer: Allergan Pharmaceuticals
Nonproprietary Name: Idoxuridine
Indications: Corneal inflammations resulting from herpes simplex.
Contraindications: Susceptibility to its components.
Dosage: Five instillations daily at 4 hrs. intervals.
Supplied: Ointment 0.5%

MYCOSTATIN Oral Suspension — Systematic Fungicide ℞

Manufacturer: E. R. Squibb and Sons
Nonproprietary Name: Nystatin
Indications: Infections of the oral cavity caused by *Candida albicans* and similar species.
Contraindication: Hypersensitivity to nystatin.
Dosage: Infants—2 cc. q.i.d.
Adults—4-6 cc. q.i.d.
Retain in mouth as long as possible. Continue treatment for 48 hours.
Supplied: Suspension: 100,000 units nystatin per cc.

VALISON LOTION — Local Corticoid ℞

Manufacturer: Schering Laboratories
Nonproprietary Name: Betamethasone valerate
Indications: Seborrheic dermatitis of the scalp.
Contraindications: Viral diseases of the skin, i.e. vaccinia and varicella.
Dosage: Apply a few drops of the lotion to the affected area; use twice daily.
Supplied: Lotion 0.1%—20 and 60 cc. plastic squeeze bottles. ◄



What goes on

a guide to continuing education

Editor's Note: Information for the "What Goes On" page should be received two months prior to the event. Address all correspondence to the Illinois Medical Journal, 360 N. Michigan Ave., Chicago, 60601.

July–National Health Council Committee on Continuing Education

1) July 8-13 *Consultation: Theory, Process, Practice*

This course focuses on the further development of the skills of the health professional in the use of the consultation process in carrying out responsibilities in voluntary, professional, and official health agencies.

Tuition: $135.00

Contact: Anna B. Brown Ph.D., M4234 School of Public Health II The University of Michigan, Ann Arbor, Mich. 48104.

University of Michigan, Ann Arbor, Michigan

2) July 15-20 *Executive Development: Power, Politics and Planning*

The foci of concern in medical care administration have shifted sharply from the clinical aspects to the interpersonal and interprofessional, the political, social and economic.

Major content of the course will include: What's Coming in Health Care, Power as a Social Phenomenon, The Use of Power as a Social Resource for Improving Community Health, Planning a Community Health Care System and others.

Tuition: $175.00 plus $10.00 registration fee

Contact: Continuing Education Program, National Health Council, 1740 Broadway, New York, N.Y. 10019.

Washington D.C.

July 9-13–American Society of Pathologists

"Preparatory Methods in Cytology"

This workshop, designed for cytotechnologists, will cover the following topics: cell fixation, special staining procedures, cell block methods and evaluation, serous effusion methods and quality control in cytopreparatory laboratory. A cytopreparatory clinic will be conducted during the course. Each registrant is urged to bring his or her own problem slides relating to preparatory techniques.

Contact: Manager, Educational Center Programs, American Society of Pathologists, 2100 W. Harrison Street, Chicago, IL 60612

Fee: $220.00 Members and $275.00 Non-Members

July 17–Chicago Lakeshore Hospital

"Social and Political Aspects of Health Care"

The program will begin at 7:30 p.m. with each panelist making a brief presentation followed by a discussion of the topic among the members of the panel. Following this exchange of views, there will be a significant period during which the audience may ask questions and pose challenges to the panelists.

Fee: $5.00

Contact: Chicago Lakeshore Hospital, 4840 North Marine Drive Chicago, IL 60640

August 20-23–The American Academy of Orthopaedic Surgeons

Emergency Care Course

This course is designed to bring the latest practical concepts and techniques concerning emergency care and transportation of the sick and injured to those with such responsibilities.

Contact: Course Chairman, Kenneth M. Sachtjen, M.D., 2704 Marshall Court, Madison, Wisconsin 53705

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Ectopic Hydroueter

(Continued from page 521)

11 mg.% and the serum creatinine was 0.85 mg.%. Follow-up excretory and retrograde urograms have demonstrated slight improvement in the degree of hydronephrosis.

Summary

A 26-year-old man was found to be severely hypertensive as a result of renal insufficiency. The pressure from a gigantic ectopic hydroureter arising from the duplicated upper segment of the left kidney was sufficient to cause obstruction to the ureter draining the lower and better renal segment. Congenital absence of the right kidney further complicated the problem. This case is reported both because of the unusual nature of the condition and because of the unusual dimensions to which the ectopic ureter dilated over a period of 26 years. Drugs used were Serpasil-reserpine and Hypaque-Sodium diatrizoate. ◄

References

1. Goldstein, A. E. and Heller, E.: "Ectopic Ureter Opening into a Seminal Vesicle." *J. Urol., 75:57, 1956.*
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3. Campbell, J. H., Pasquier, C. M., Jr. and St. Martin, E. C.: "Ureteral Ectopic in Adult Male Patients." *J. Urol.* 81:99, 1959.
4. Cox, C. E. and Hutch, J.: "Bilateral Single Ectopic Ureter: A Report of Two Cases and Review of the Literature." *J. Urol.,* 95:493, 1966.
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EKG of the month

(Continued from page 519)

Answers: *1. d, 2. b & d.* The ECG rhythm strip demonstrated junctional (nodal) premature beats. The first, fifth, seventh, and ninth beats are all premature preceded by an inverted P wave. The PR interval is 0.08 sec. An inverted P wave preceding a premature beat with a PR interval less than 0.12 sec. is diagnostic of a premature junctional beat. Aberrant ventricular conduction may occur as in the present strip which resembles premature ventricular beats.

The junctional prematures usually conduct retrograde to the sinus node and reset it so that the pause is less than fully compensatory. Ventricular prematures usually do not reset the sinus node thus producing fully compensatory pause. (The interval between the two normally conducted beats that surround the ventricular premature beat is exactly twice the normal P-P interval.). ◄

Twenty-five Clinics For Crippled Children Listed for July

Twenty-five clinics for Illinois' physically handicapped children have been scheduled for July by the University of Illinois, Division of Services for Crippled Children. The Division will conduct nineteen general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social, and nursing services. There will be six special clinics for children with cardiac conditions. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

July 5 Sterling—Sterling Community Hospital
July 5 Lake County Cardiac—Victory Memorial Hospital
July 9 Peoria Cardiac—St. Francis Children's Hospital
July 10 Peoria—St. Francis Children's Hospital
July 10 E. St. Louis—Christian Welfare Hospital
July 11 Hinsdale—Hinsdale Sanitarium
July 11 Champaign-Urbana—McKinley Hospital
July 12 Macomb—McDonough District Hospital
July 12 Effingham—St. Anthony's Memorial Hospital
July 12 Springfield—St. John's Hospital
July 12 DuQuoin—First Methodist Church
July 13 Chicago Heights Cardiac—St. James Hospital
July 17 Rock Island—Moline Public Hospital
July 17 E. St. Louis—Christian Welfare Hospital
July 17 Quincy—Blessing Hospital
July 18 Joliet—St. Joseph's Hospital
July 19 Elmhurst Cardiac—Memorial Hospital of DuPage County
July 19 Decatur—Decatur Memorial Hospital
July 23 Peoria Cardiac—St. Francis Children's Hospital
July 24 Peoria—St. Francis Children's Hospital
July 24 Belleville—St. Elizabeth's Hospital
July 25 Elgin—Sherman Hospital
July 25 Centralia—St. Mary's Hospital
July 25 Rockford—St. Anthony's Hospital
July 27 Chicago Heights Cardiac—St. James Hospital

View Box

(Continued from page 540)

Diagnosis—*Milk of calcium renal stones.* These rare calculi typically show layering in the upright position. The Scout film on Figure 1 revealed an opacity in the right upper quadrant suggestive of a gallstone. The upright film revealed a layering effect with the density occupying the dependent part of a fluid filled sac. This type of stone usually consists of minute granules of calcium carbonate in a fluid filled dilated calyx or cyst. An IVP later performed on this patient revealed a calyceal diverticulum off the lower pole calyx containing the fluid filled calcium. ◄

Colorectal Adenomas and Adenocarinomas

(Continued from page 531)

majority of colorectal carcinomas arise *de novo* from normal appearing mucosa or from villous adenomas. This being the case, the risks involved in removing or destroying all colorectal polyps (undiagnosed lesions) in an attempt to prevent cancer are not warranted. The morbidity and mortality of such an approach far exceed those of delayed recognition of cancers that might have arisen from simple adenomas.

The problem is determining which undiagnosed lesions are cancers and which are not. Since a definitive diagnosis must come from histologic examination, removal of an undiagnosed lesion is necessary for a final diagnosis. But an absolute diagnosis is not required for every undiagnosed polyp. Some polyps have features that make them less likely to be cancers—size, pedunculation and a smooth surface. These are features that can be determined by X-ray examination or by sigmoidoscopy or by fiberoptic colonscopy. A shaggy or broken surface calls for histologic diagnosis no matter the size.

A smooth polyp of less than one centimeter and on a stalk can be followed with relative safety. Sessile polyps offer a smaller safety factor, but they can be followed with equanimity if they can be shown by endoscopy to have a smooth and unbroken surface. ◄

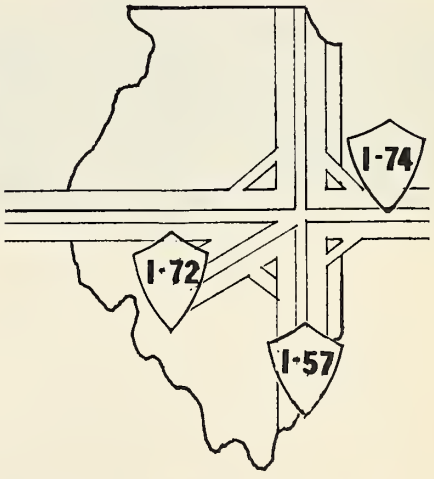
References

A complete bibliography for "Colorectal Adenomas and Adenocarcinomas" may be obtained from the *Illinois Medical Journal,* 360 N. Michigan Ave., Chicago, 60601.

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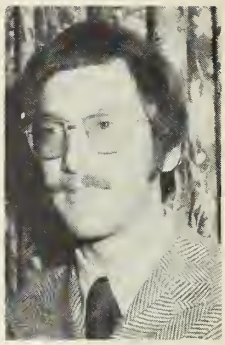
New Employees at ISMS


Shannon


Magness


Kjellander


Harpe


Boress

Catherine Shannon has been hired as an Insurance Clerk for the new ISMS malpractice program, which is under the administration of Johnson & Higgins Co. Jack Magness is the new Executive Assistant in the Division of Publications and Scientific Services. Mr. Magness replaces H. Michael Wild, who is the new Executive Secretary for Kane County Medical Society. Bob Kjellander is the Public Affairs Assistant in the Division of Government Affairs. Shidler Harpe, former Director of Officer Service at the American Medical Association is the new Director of the Division of Public Relations. Larry Boress has assumed a new position as Executive Assistant in the Division of Health Care Delivery.

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From AMA . . .

Use of Physician's Name in Commercial Advertising

From time to time in the past physicians have permitted the use of their names in commercial advertisements. It was not a widespread, frequent or accepted practice.

At this time the AMA Judicial Council sees definite evidence of a break with ethical tradition. Commercial advertisement carrying the name, photograph and professional appointments of physicians are conspicuous in both public and professional periodicals.

Regardless of disclaimers and alleged educational claims for the ad, the intent of using a physician's name and photograph in an advertisement is simply to draw attention to the ad. The physician who permits his name and photograph to be so used is permitting himself and his profession to be exploited.

The Judicial Council has previously stated that it is demeaning to the medical profession for the physician to permit the use of his name and professional status in the promotion of commercial enterprises. Out of respect for his profession, a physician should not allow his name or the prestige of his professional status as a physician to be used in the promotion of commercial enterprises.

To the extent that the facts of a particular case indicate that the honor and dignity of the profession are denigrated then charges of conduct contrary to Section 4 of the Principles of Medical Ethics should be brought before and fully reviewed by the ethics committee of the physician's component medical society.

Circumstances will suggest and facts disclose whether some consideration of value was given the physician for the use of his name and photograph by the advertiser. Circumstances will indicate the purpose of the advertisement.

In view of the proliferation of advertising of this nature, the Judicial Council reaffirms its opinion*:

> It is demeaning to the medical profession for a physician to permit the use of his name and professional status in the promotion of commercial enterprises. A physician may freely engage in business ventures outside the practice of medicine. However, out of respect for his profession, he should not allow his name or the prestige of his professional status as a physician to be used in the promotion of commercial enterprises.

In conclusion, the Council condemns as unethical the action of the physician who *is found* to place personal, selfish, financial, or venal interests ahead of the high ideals of the medical profession. The Council wishes to call this reaffirmation of its opinion to the attention of all physician. ◄

*Adopted by the AMA Judicial Council, April 28, 1973.

U.S. Doctors to Attend Yugoslav Environmental Meeting

Environmental health experts from throughout the world will attend an International Conference on Environmental Health next fall in Yugoslavia. The conference will be held Oct. 23-26, 1973, in Primosten, a resort area near the city of Split on the Adriatic Coast, the AMA reported.

Sponsored by the Union of Medical Societies of Yugoslavia with cooperation of the American Medical Association and the World Medical Association, the conference will be supported by the Bureau of Community Environmental Management, Health Services and Mental Health Administration, U.S. Department of Health, Education and Welfare.

The program is planned to stimulate an exchange of health and medical information with emphasis on specific programs and activities, epidemiological and other research, and consideration of prevention strategies.

Physicians, allied health professionals and others in the United States interested in attending the conference may obtain further details by writing to the Transportation Section, American Medical Associaiton, 535 N. Dearborn St., Chicago, 60610.

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Ruptured Spleen

(Continued from page 524)

The spleen continues to move when the patient has stopped and its capsule is torn at one of it's fixed attachments. Figure 4 was taken of a patient who fell three stories in an open elevator shaft. One can see the capsular tear at the splenocolic ligament.

I would like to stress the importance of obtaining chest X-rays immediately after operation in any patient who has suffered sufficient injury to the chest wall to rupture their spleen. Frequently the preoperative chest film will not reveal a pneumothorax, however, after the patient is placed on the positive pressure respiration in the operating room, a significant pneumothorax can develop. The operating surgeon should be aware of this potential danger. This patient did in fact develop a small pneumothorax postoperatively which did not require treatment.

Dr. Thomas Kornmesser: How accurate is angiography in cases like this?

Dr. Stuart M. Poticha: Angiography is probably the most accurate ancillary test used to determine injury to the spleen. With immediate rupture of the spleen, the physical findings are usually so dramatic that exploratory laparotomy is the only step indicated. However, when one suspects a subcapsular splenic injury, angiography is extremely valuable in diagnosing the injury before delayed rupture occurs. ◄

MDs Asked to Refer Patients With Pulmonary Fibrosis

The cooperation of physicians has been requested in the referral of patients with interstitial pulmonary fibrosis for studies being conducted jointly by the National Institute of Arthritis, Metabolism, and Digestive Disease and the National Heart and Lung Institute at the Clinical Center, National Institutes of Health, Bethesda, Md. Patients 40 years of age or older are needed.

Of particular interest are the etiology, mechanisms, and treatment of interstitial pulmonary fibrosis secondary to scleroderma or arthritis (rheumatoid or idiopathic).

Interested physicians may write to Harold H. Newball, M.D.; Clinical Center, Room 6-D-05; National Institutes of Health, Bethesda, Md., 20014; or telephone (301) 496-1597.

(Medical Tribune Report).

Announcement

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BLOOD VESSEL SURGERY, One Week, October 8
BASIC GYNECOLOGY, One Week, October 1
BASIC OBSTETRICS, One Week, October 8
PULMONARY FUNCTION TESTING, 3 Days, July 11
FLUIDS & ELECTROLYTES, One Week, September 24
BASIC ELECTROCARDIOGRAPHY, One Week, October 15
BASIC INTERNAL MEDICINE, One Week, October 22

Information concerning numerous other continuation courses available upon request.

Address:
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Obituaries

*Anderson, Kenneth W., Chicago, died February 16, 1973.

*Becker, Leonard A., Elmhurst, died April 1 at the age of 59. He practiced dermatology in Chicago and received his medical degree from the University of Illinois.

*Biezis, Stephen, Chicago, died April 6, 1973.

*Hannan, Martin L., Chicago, died April 6, 1973.

*Hoover, Allan, Chicago, died April 25, 1973.

**Nortell, Joseph L., Oak Park, died April 15, at the age of 89. He was a former Chief of Surgery at West Suburban Hospital, Oak Park. He had been a physician since 1906.

**Pagano, Ralph, Clarendon Hills, died April 1973. He had been a physician for more than 50 years.

**Schoch, Andrew Clarence, Chicago, died February 6, 1973. He had been a physician for more than 50 years.

**Vail, Derrick, Lake Bluff, died this April at the age of 74. An internationally known ophthalmologist, he died while attending a medical conference in London. He was former head of the Department of Ophthalmology at Northwestern University Medical School. At the time of his death, he was professor emeritus at Northwestern University. During his medical career Dr. Vail held various positions, including: editor of the *American Journal of Ophthalmology* from 1940 to 1965; head of the eye departments of the Veterans Administration Research Hospital and Passavant Memorial Hospital and the first United States citizen to serve as President of the International Council of Ophthalmology.

**Weissman, Morris, California, died October 14, 1973. He had been a physician for more than 50 years.

**Zalatoris, Peter Z., died at the age of 86. He retired four years ago after 48 years as a South Side physician and surgeon with offices also on the south side.

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Physician Recruitment Program

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program. This is a free service to all physicians.

Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 360 North Michigan Ave., Chicago, 60601.

ALEDO: Mercer County, 17,000 population, needs additional family physicians. 4 active physicians at present. General acute hospital in Aledo. High quality medical care economically rewarding. Thirty miles from metropolitan quad-city area. Good small community for family living. Contact: Shirley Lindberg or Monty McClellan, M.D., 308 NW Forth Street, Aledo, 61231, 309-582-5156. (9)

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CHICAGO: Local Medical Examiner, half or fulltime, 5 days, M-F. Large company downtown with professional staff, modern facilities, needs Illinois licensed internist, G.P., or surgeon. Salary negotiable, excellent benefits. Call 431-4671 or write Room 708, 122 South Michigan, Chicago, 60603 for information. (9)

DU QUOIN: Population 7,000, 75 miles South of St. Louis and 20 miles north of Southern Illinois University. 1 Surgeon and 1 General Practitioner & OB GYN. Excellent opportunity for both to build lucrative practice. Brand new hospital with all new equipment and facilities. Present hospital board and staff will support. Office spaces can be made available. Area has good recreational facilities, good school and shopping areas. Contact W. M. Thornburg, M. D., 111 W. Main St., Du Quoin 62832 618-542-2137. (9)

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FAIRFIELD: G.P. or internist interested family practice to join group three physicians—GP, board surgeon, board OB-GYN man—town 6,500 population. Generous salary, full association one year, if mutually agreeable. Excellent hospital in town. Interview and all expenses paid. Contact Sigmund Konarski, M.D. 101 E. Center St., Fairfield, 62837, 618-842-2187. (10)

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WANTED . . . PHYSICIAN to practice in new clinic. Ideal location in county seat of Marquette County. Progressive community in resort and reecreation area. Excellent place to live and work. Financial arrangements can be made. Contact: Mayor Ken 8entley, Montello, Wisconsin. Telephone: (414) 297-2474.

WANTED: PHYSICIANS, SPECIALISTS OR GENERALISTS, who want to discover Ozaukee County, Wisconsin. A beautiful blend, rural agricultural with many cities and villages growing and progressing but still preserving an Early American charm. This prime recreation area bordering Lake Michigan has a modern progressive hospital at Port Washington serving the population of 55,000 but short the necessary link—Physicians. Contact George Seidenstricker, St. Alphonsus Hospital, 743 North Montgomery Street, Port Washington, Wisconsin 53074. Phone: 414-284-5511.

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